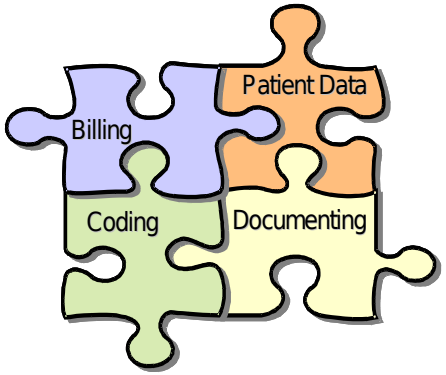
CORE COMPETENCIES

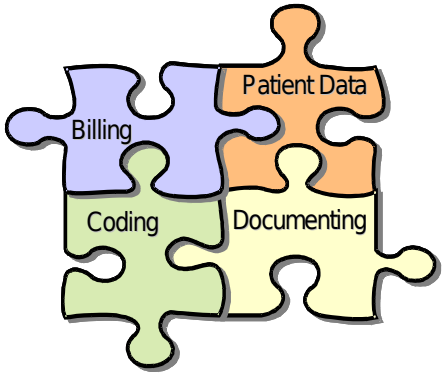
2005 UBU/UBO Conference
UBO Basic (Track 3)
Thursday - May 19



Contents:

1. Standard Insurance Table (Dellaporta , Steve and Czaja, Michele)
2. DEERS Other Health Insurance (Dellaporta , Steve and Czaja, Michele)
3. Understanding the UB-92 Data Elements for Cle an Claims (Borchert, Lorrie)
4. Conference Wrap-Up (Yoder, Lt Col Jeanne)

CORE COMPETENCIES



Standard Insurance Table

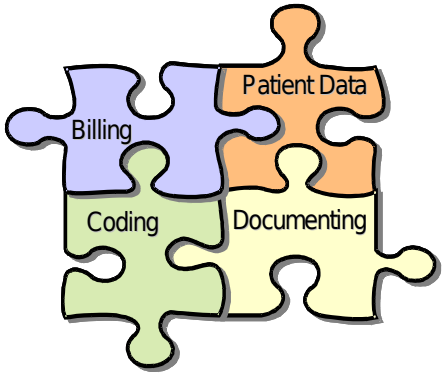
Steve Dellaporta and Michele Czaja, DMDC

May 19, 2005

Track 3, UBO Basic

CORE COMPETENCIES

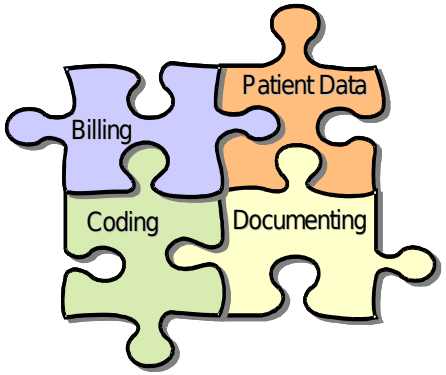
Objectives



- Understand the Master SIT Process on DEERS
- Understand the CHCS Pre-Conversion Process
- Understand the MTF SIT Web Application

CORE COMPETENCIES

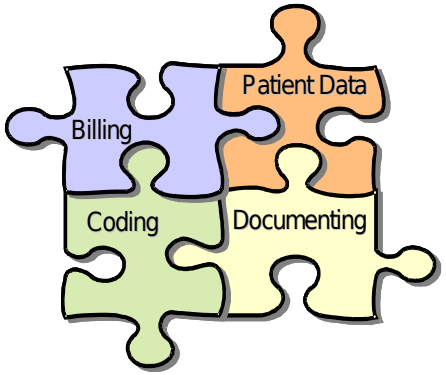
The Quest for SIT – The Journey Begins –



1. System to System uses SOAP/XML format over VPN using HTTP protocol
2. OHI/SIT Web Application

CORE COMPETENCIES

VPOC validates and approves all adds/updates to the Master SIT



DEERS

Master SIT

OHI

Local Holders of the SIT:

•Subscribe daily to DEERS for updates to the SIT

PDTS

Local SIT

Local OHI

DOES MCSCs & DP

TDEFIC & MCSCs Claims

Local SIT

Local OHI

CHCS 1

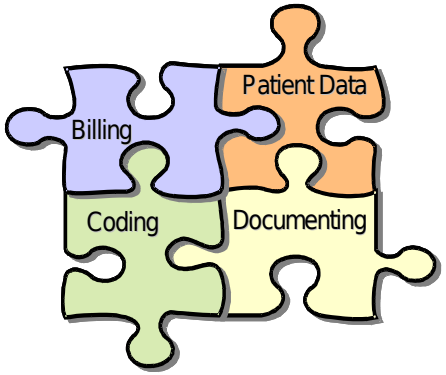
Local SIT

Local OHI

TPOCS

CORE COMPETENCIES

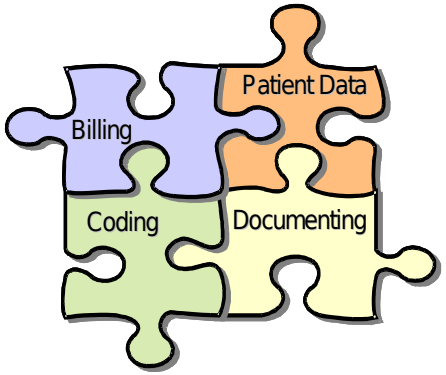
Two as One
– Daily Subscription –



- Daily Subscription
  - Full Subscription
    - The full table with all entries
- Partial Subscription
  - Changes since last subscription
  - Changes for, up to, the last seven days

CORE COMPETENCIES

SIT - The Search for Self

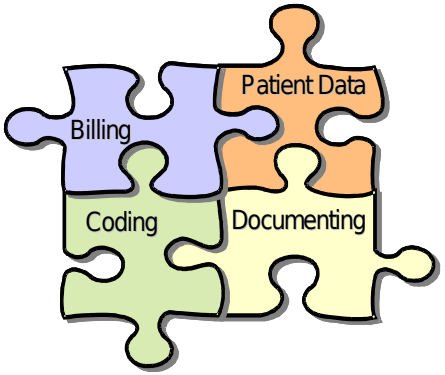


SIT consists of:

- Health Insurance Carrier (HIC) and HIC Coverage:
  - Carrier:
    - Name
    - HIC_ID assigned by DEERS
  - Coverage
    - Comprehensive Medical (default) (XM), Medical (MD); Dental (DN); Inpatient (IP); Outpatient (OP); Long Term Care (LT); Pharmacy (RX); Mental Health (MH); Vision (VI); Partial Hospitalization (PH); Skilled Nursing (SN)

CORE COMPETENCIES

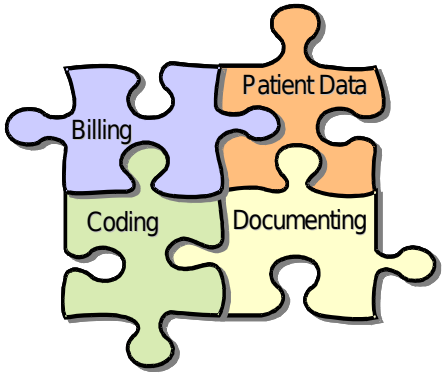
When Two is Better Than One



- HIC
- HIC Coverage:
  - HIC_CVG_TYP_CD: Medical (MD)
  - HIC_STAT_CD: S=standard
  - HIC_CVG_PYR_TYP: B=both Institutional and Professional
- HIC Coverage:
  - HIC_CVG_TYP_CD: Pharmacy (RX)
  - HIC_STAT_CD: S=standard
  - HIC_CVG_PYR_TYP: B=both Institutional and Professional

CORE COMPETENCIES

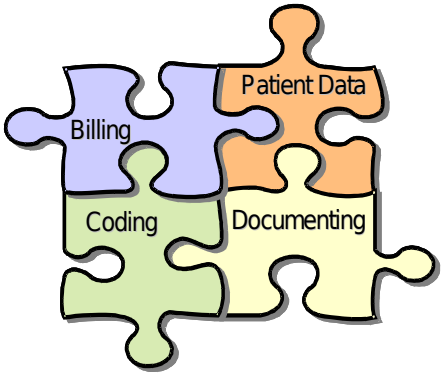
SIT
What's Up With That?



1. VPOC will manage the Master SIT directly on DEERS – all changes immediately available to all clients
2. CHCS will receive updates hourly from the Master SIT

CORE COMPETENCIES

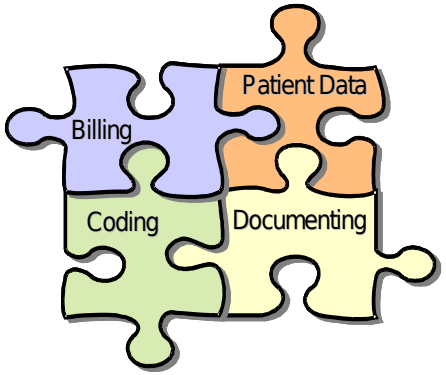
SIT
What's Up With That?



3. The SIT will capture multiple coverages for a Carrier instead of creating multiple Carriers
4. Pharmacy is a type of Coverage, not a type of Carrier

CORE COMPETENCIES

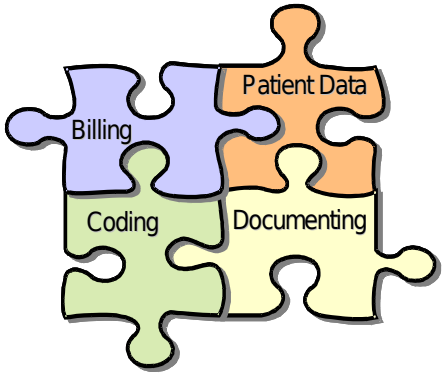
CHCS Pre-Conversion

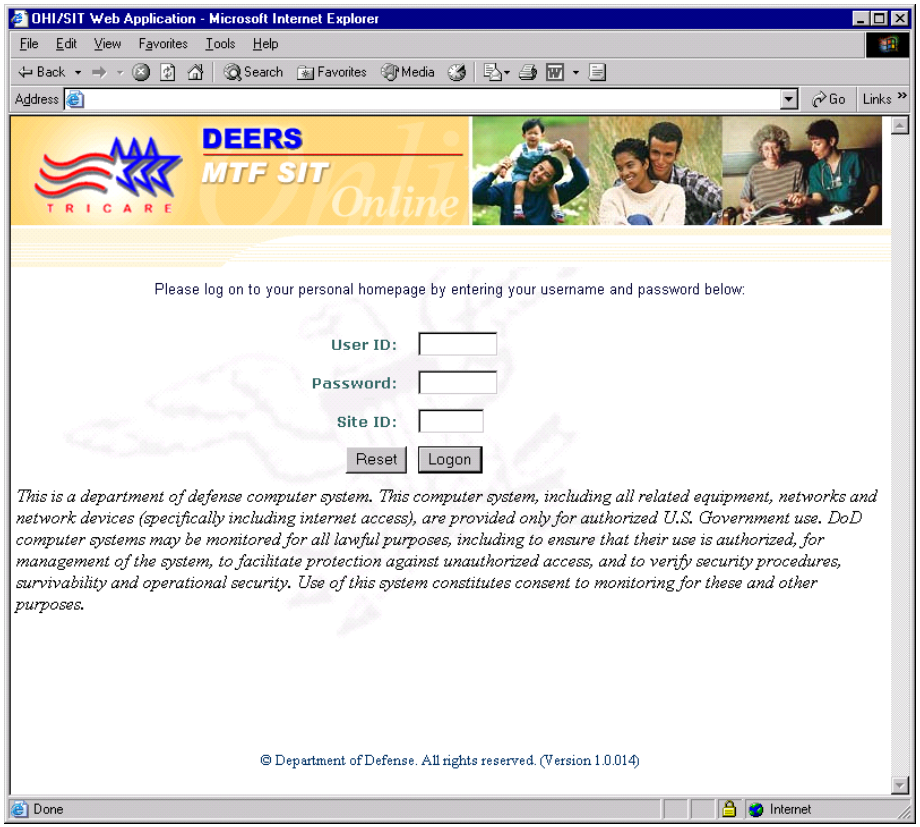


- Overview of MTF Pre-Conversion activity presented by Terri Boyd, Altarum

CORE COMPETENCIES

MTF SIT Web Application




OHI/SIT Web Application - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Address
Go Links
DEERS
MTF SIT
TRICARE
Online
Please log on to your personal homepage by entering your username and password below:
User ID:
Password:
Site ID:
Reset
Logon
This is a department of defense computer system. This computer system, including all related equipment, networks and network devices (specifically including internet access), are provided only for authorized U.S. Government use. DoD computer systems may be monitored for all lawful purposes, including to ensure that their use is authorized, for management of the system, to facilitate protection against unauthorized access, and to verify security procedures, survivability and operational security. Use of this system constitutes consent to monitoring for these and other purposes.
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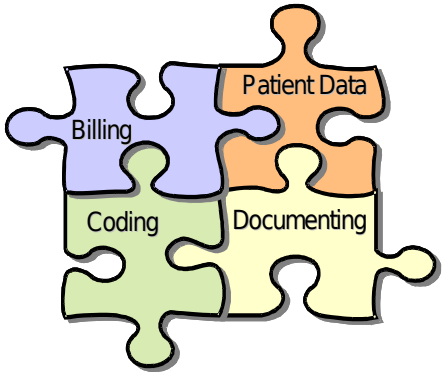
Done
Internet

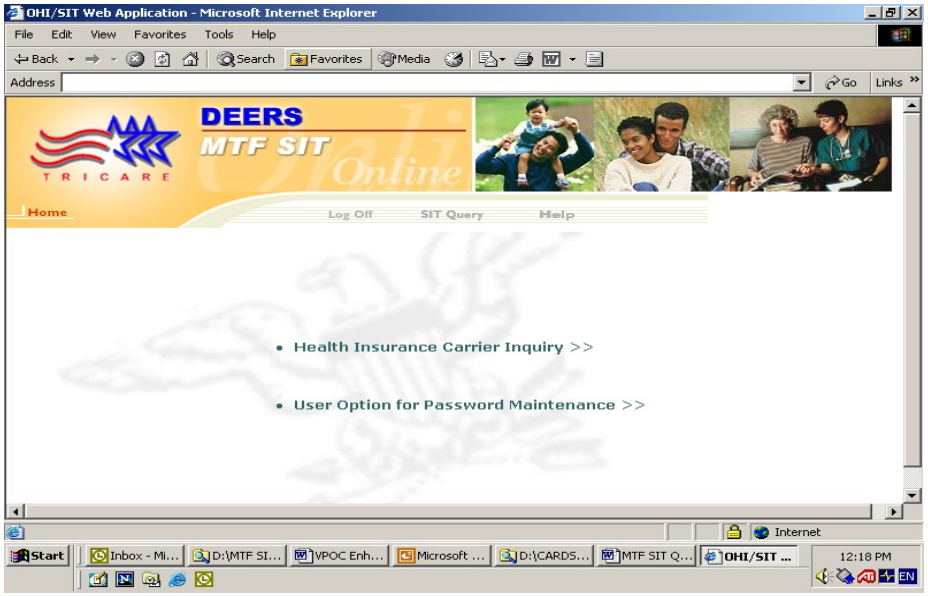
Logon with:

- **User ID**
- **Password**
- **Site ID**

CORE COMPETENCIES

MTF SIT Web Application



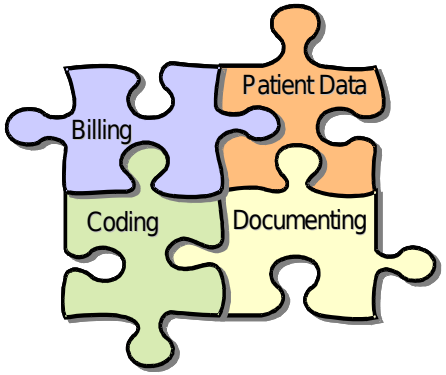


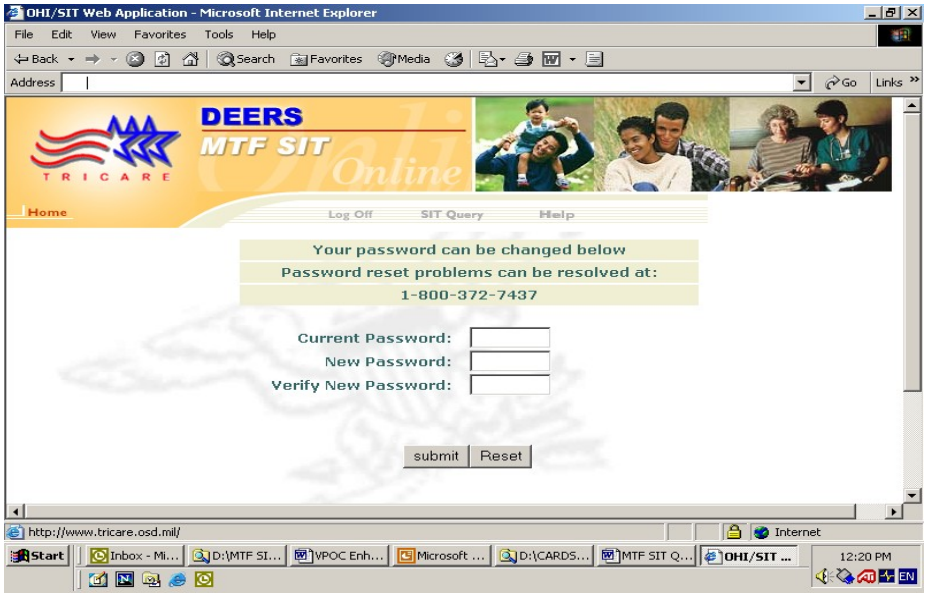
The first time you log into MTF SIT, click on:

- **User Option for Password Maintenance >>**

CORE COMPETENCIES

MTF SIT Web Application





Input:

- **Current Password**
- **New Password**
- **Verify New Password**

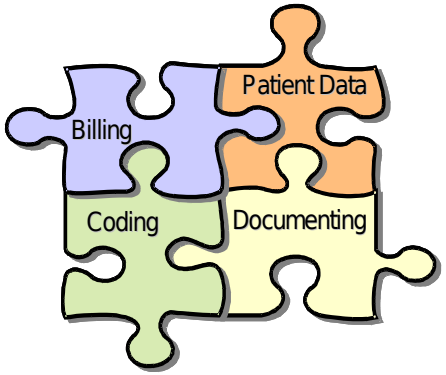
Click Submit.

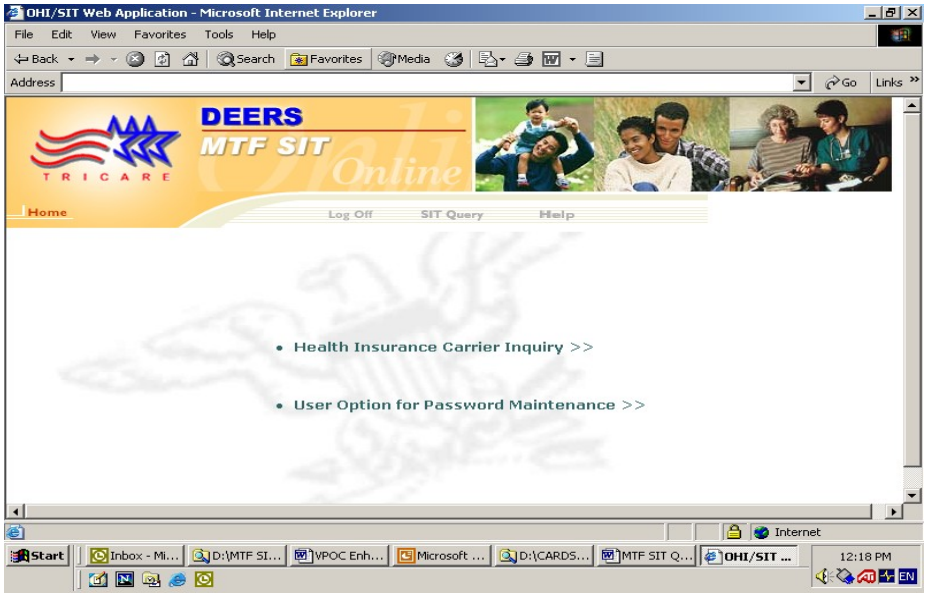
Password must contain:

- **One Uppercase Letter**
- **One Lowercase Letter**
- **One Number**
- **One Special Character**
- **Cannot repeat any**

CORE COMPETENCIES

MTF SIT Web Application



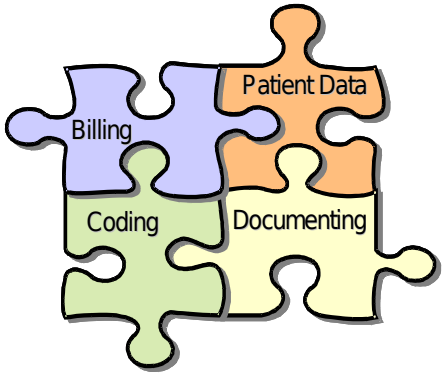


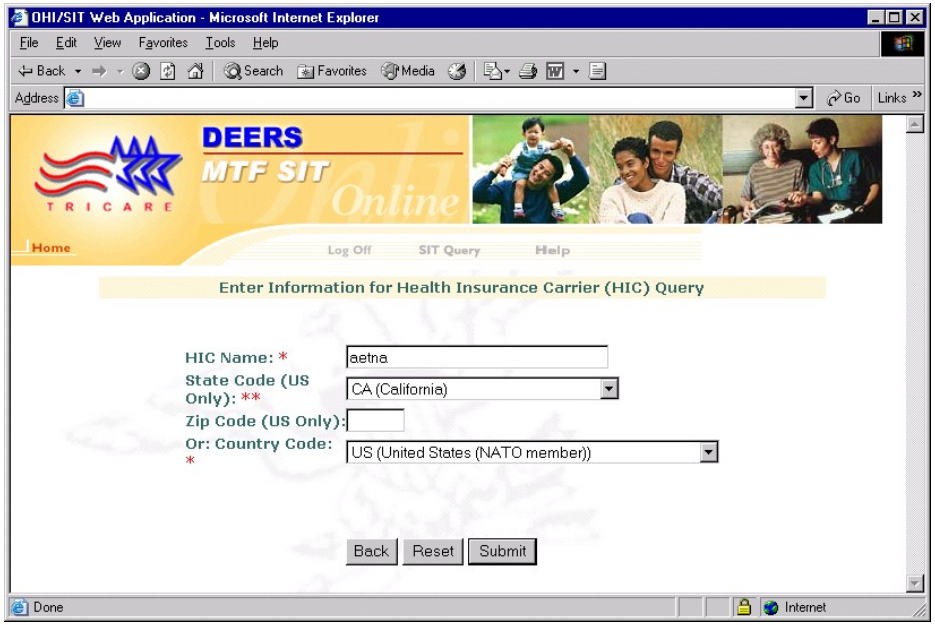
Click on:

- **Health Insurance Carrier Inquiry >>**

CORE COMPETENCIES

MTF SIT Web Application





Perform a SIT Inquiry

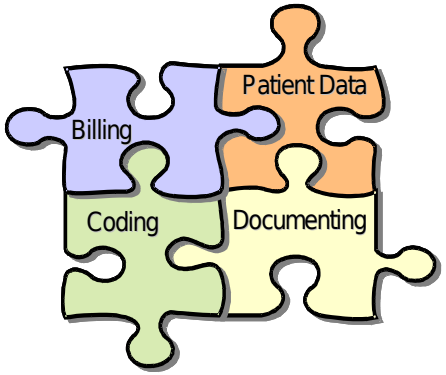
Input:

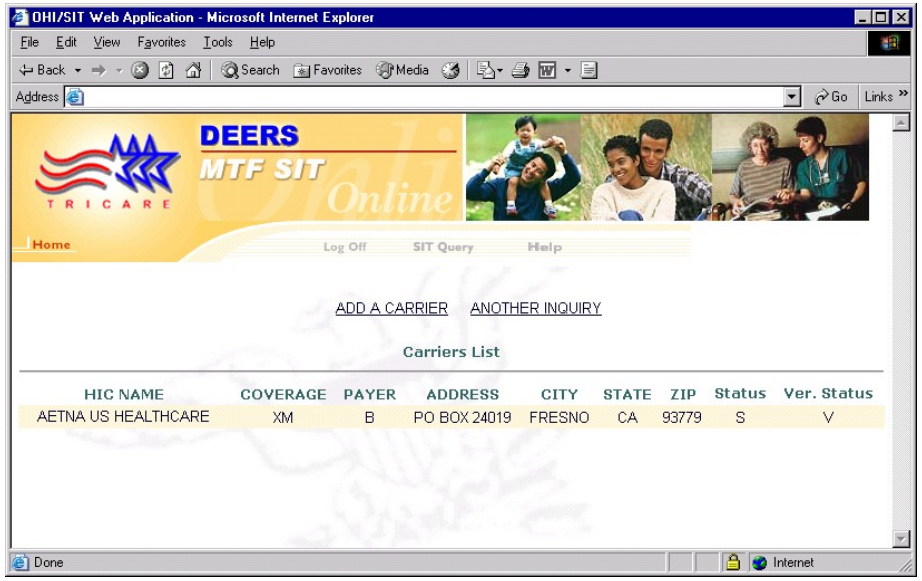
- **HIC Name**
- **State Code if US or Country Code**

Click <u>Submit</u>.

CORE COMPETENCIES

MTF SIT Web Application





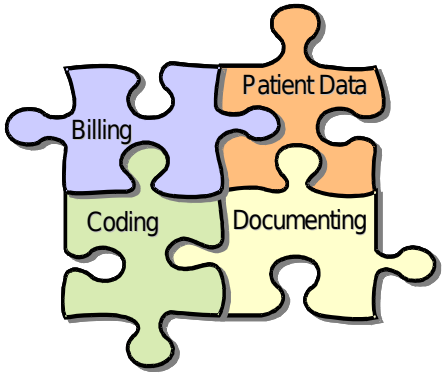
Review results.

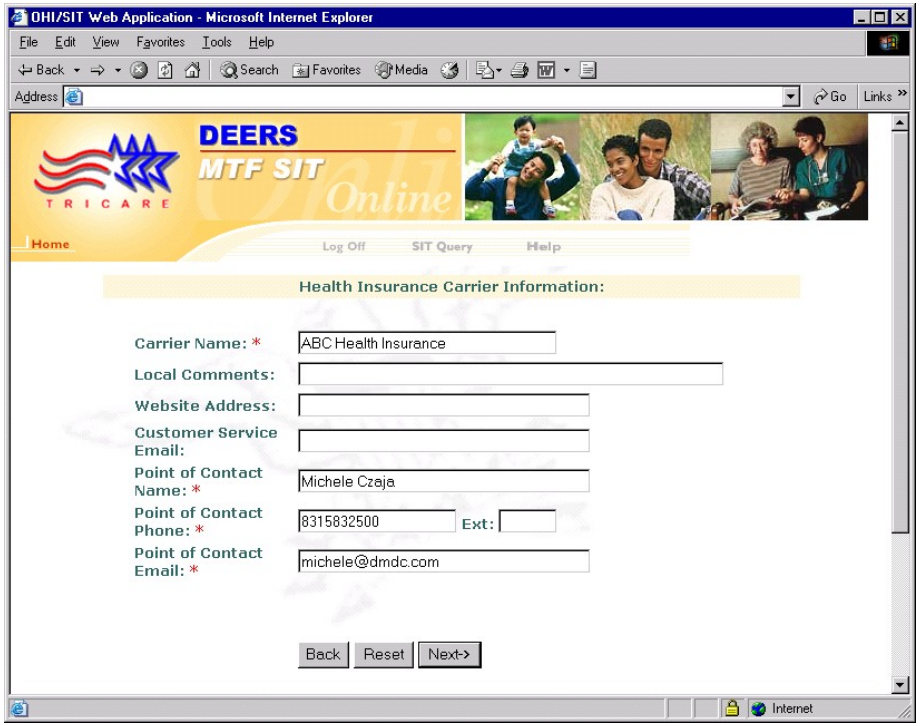
If Carrier or Claims Address is not returne Click ADD A CARRIER.

If you want to view Carrier detail, place the cursor on the Carrier Name and click

CORE COMPETENCIES

MTF SIT Web Application

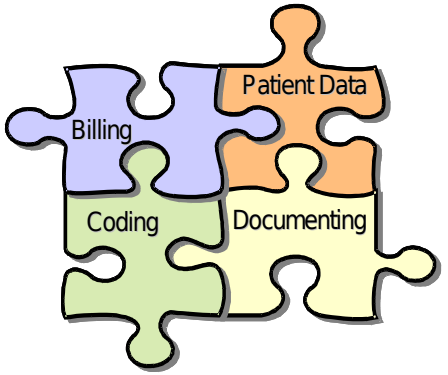


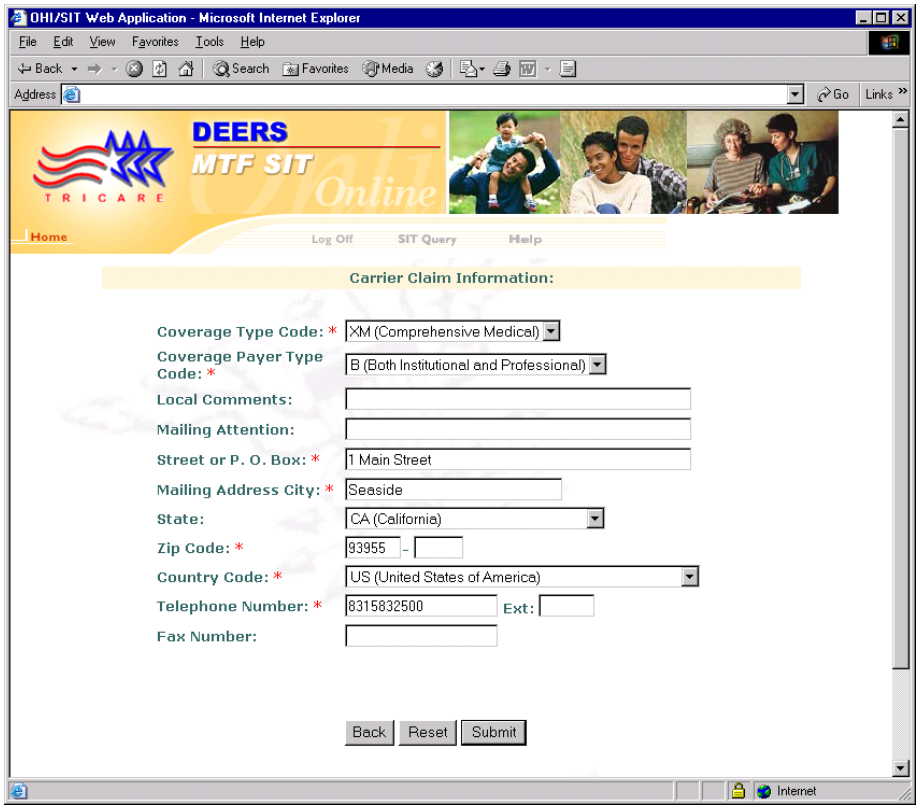


To Add a Carrier:

- **Input all required fields (marked with red asterisk).**
- **Point of Contact is the person inputting the Carrier. TMA UBO may contact the POC during the verification process.**
- **Click Next->.**

MTF SIT Web Application





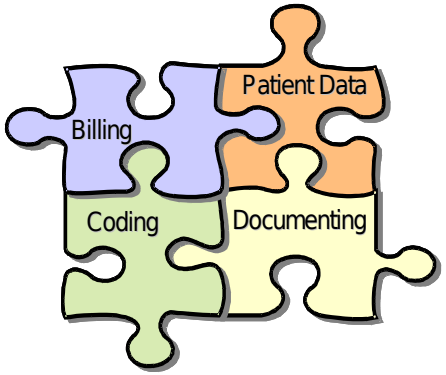
Add the Claims Address:

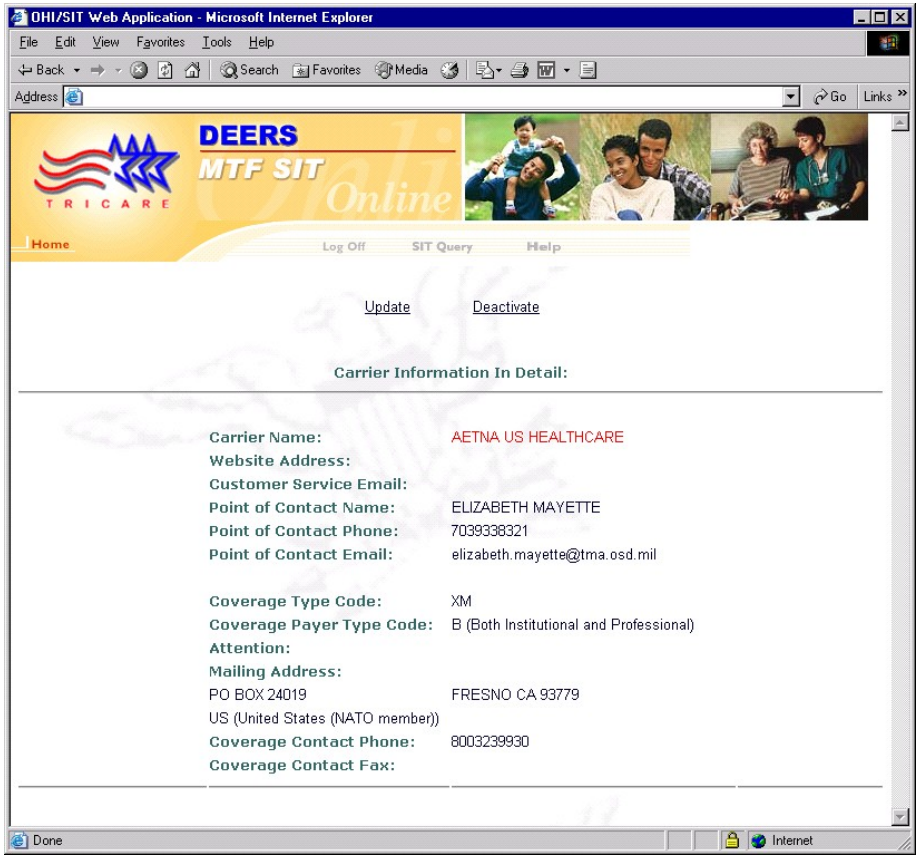
- **Input all required fields (marked with red asterisk).**

Click <u>Submit</u> to complete the Carrier Add.

CORE COMPETENCIES

MTF SIT Web Application

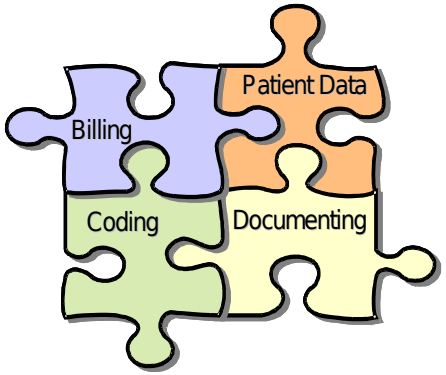


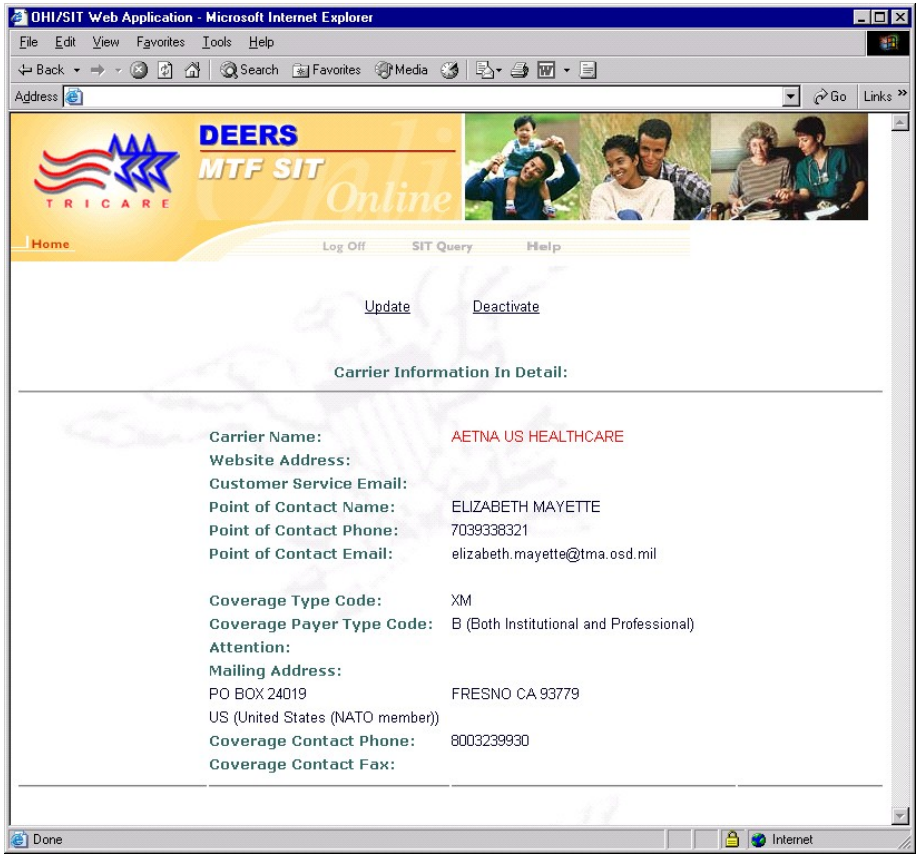


- **To Update a Carrier and/or Claims Address:**
- **Click <u>Update</u>.**
- **Input all required fields (marked with red asterisk) for the Carrier and Claims Address.**
- **Click <u>Submit</u> to complete the Update.**

CORE COMPETENCIES

MTF SIT Web Application



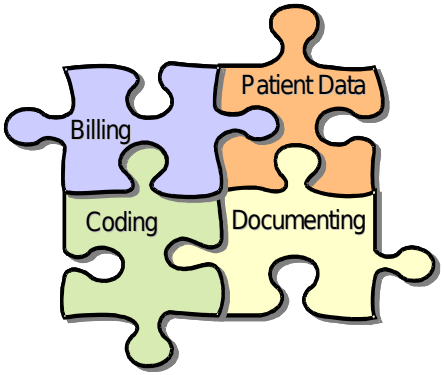


Do not Deactivate a Carrier during Pre-Conversion.

TMA UBO will reject a deactivation submitte by an MTF during Pre-Conversion.

CORE COMPETENCIES

MTF SIT Web Application

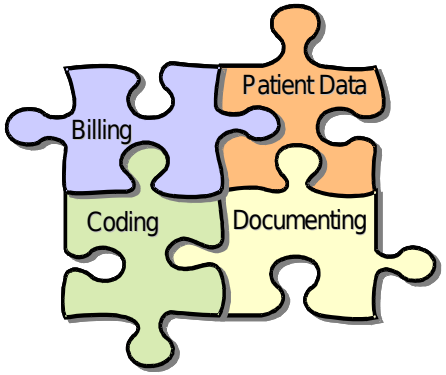


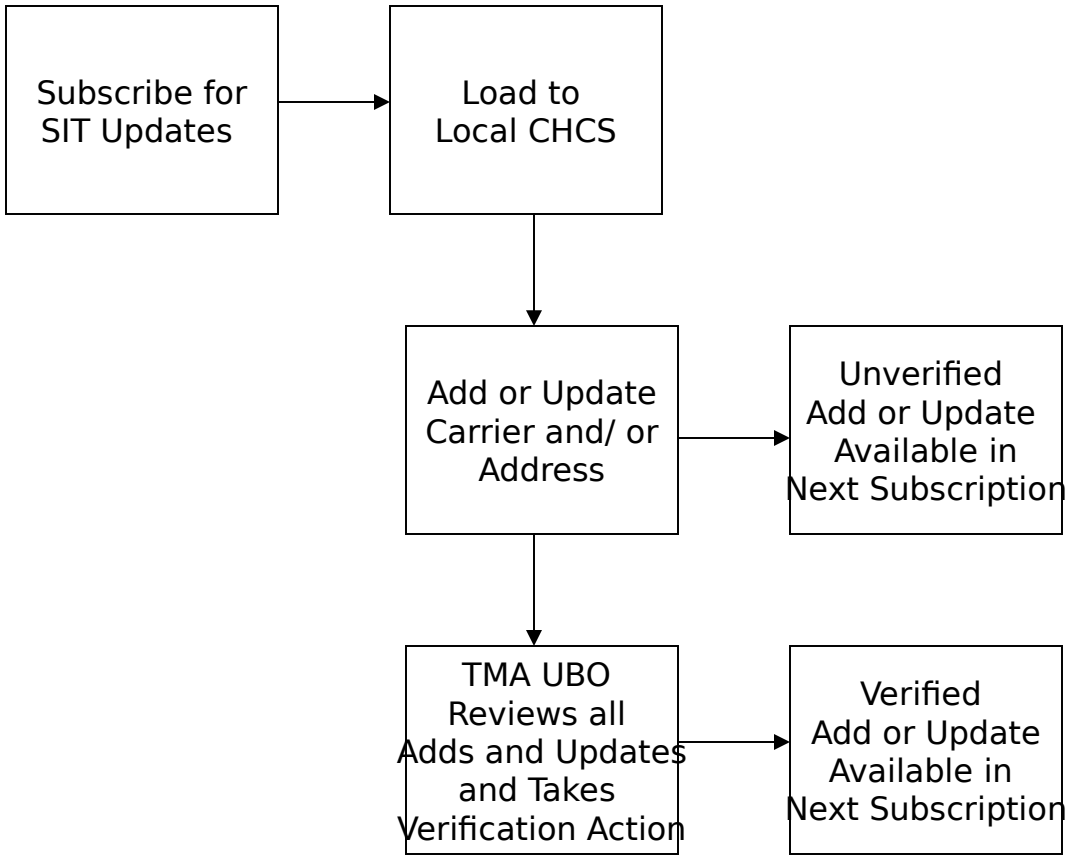
If you make a mistake and wish to cancel the carrier after the Add is complete:

- **Click <u>Cancel.</u>**
- **Only an unverified Carrier may be cancelled.**
- **You can only Cancel Adds performed at your site.**

CORE COMPETENCIES

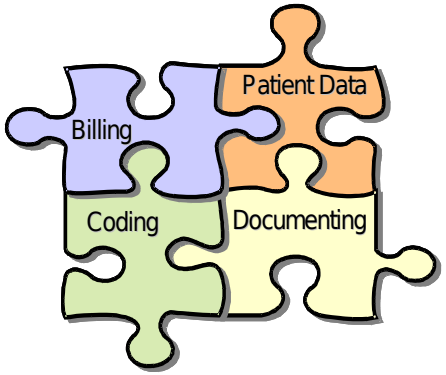
SIT Actions




Subscribe for SIT Updates
Load to Local CHCS
Add or Update Carrier and/ or Address
Unverified Add or Update Available in Next Subscription
TMA UBO Reviews all Adds and Updates and Takes Verification Action
Verified Add or Update Available in Next Subscription

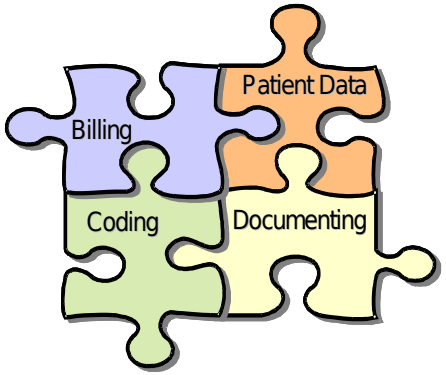
CORE COMPETENCIES

SIT Add



- Add New Carrier and Coverage (Claims Address)
- Add New Coverage to an Existing Carrier

CORE COMPETENCIES

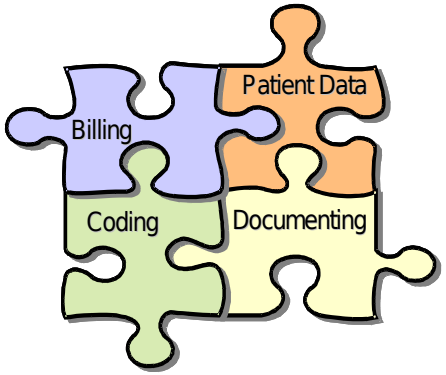


SIT Update

- Update Carrier and Coverage
- Update Carrier Only
- Update Coverage Only

CORE COMPETENCIES

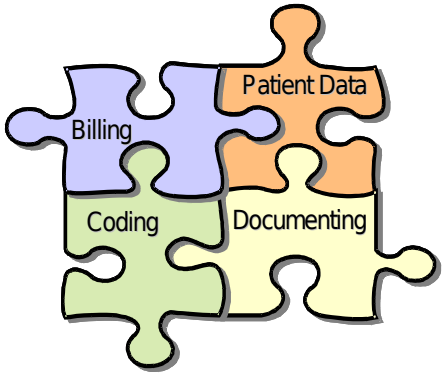
SIT Deactivate



- Deactivate Carrier

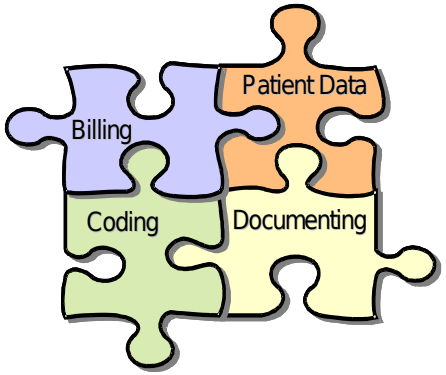
CORE COMPETENCIES

SIT Cancel



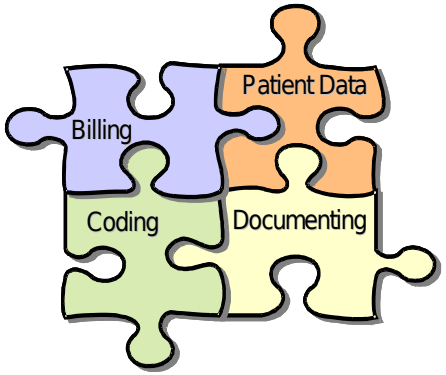
- Cancel the Add of a Carrier and a Coverage
- Cancel the Add of a Coverage

CORE COMPETENCIES



Action	HIC_ACTN_CD	HICC_ACTN_CD
Add a Carrier and Coverage(s):	A	A
Add a Coverage to an existing Carrier:	N	A
Update Carrier and Coverage:	U	U
Update Carrier only:	U	*
Update Coverage(s) only:	N	U
Cancel Carrier and all Coverage(s):	C	*
Cancel Coverage(s) only:	N	C
Deactivate Carrier and all Coverage(s):	D	*

CORE COMPETENCIES



DEERS Other Health Insurance

Steve Dellaporta and Michele Czaja, DMDC

May 19, 2005

Track 3, UBO Basic

CORE COMPETENCIES

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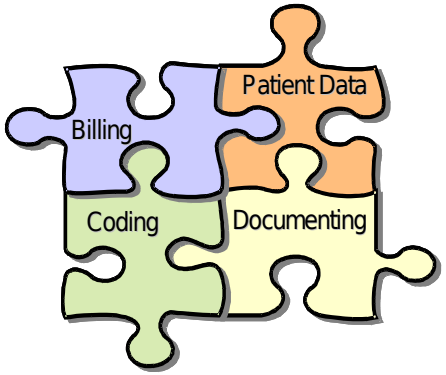
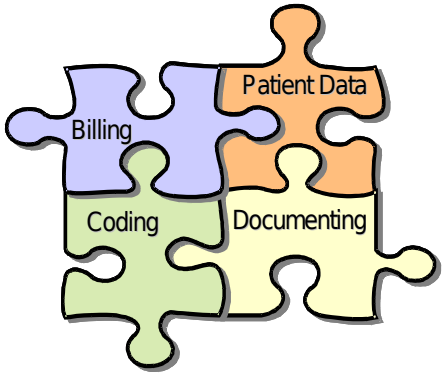


- Be familiar with the OHI Process on DEERS
- Be familiar with the format of OHI on DEERS
- Be familiar with the OHI maintenance actions on DEERS

CORE COMPETENCIES

The Quest for OHI – The Journey Begins –



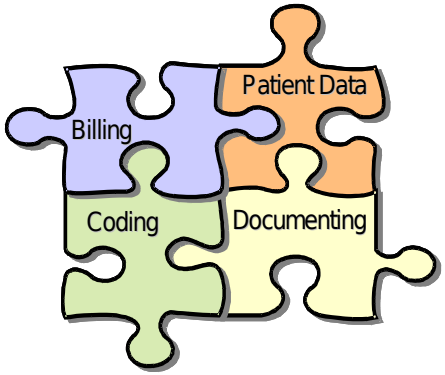
1. System to System uses SOAP/XML format over VPN using HTTP protocol
2. OHI/SIT Web Application

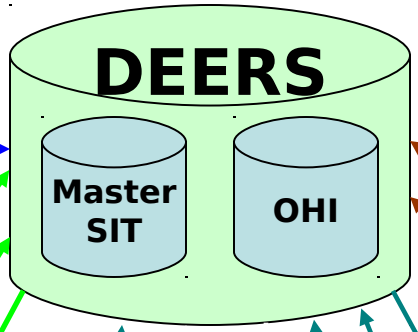
CORE COMPETENCIES

VPOC validates and approves all adds/updates to the Master SIT

Local Holders of the SIT:

- Subscribe daily to DEERS for updates to the SIT





DOES MCSCs & DP

TDEFIC & MCSCs Claims

Local SIT

Local OHI

CHCS 1

Local SIT

Local OHI

TPOCS

PDTS

Local SIT

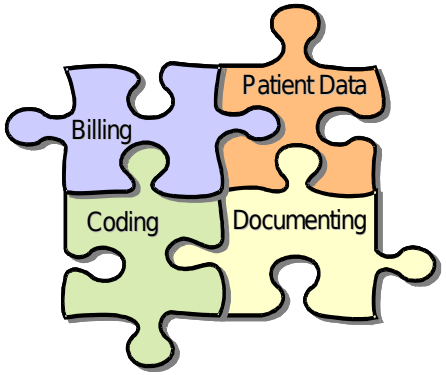
Local OHI

Each of the activities may do an:

- OHI Inquiry
- OHI Add
- OHI Update
- OHI Cancel

CORE COMPETENCIES

OHI Policy
Two Equals One

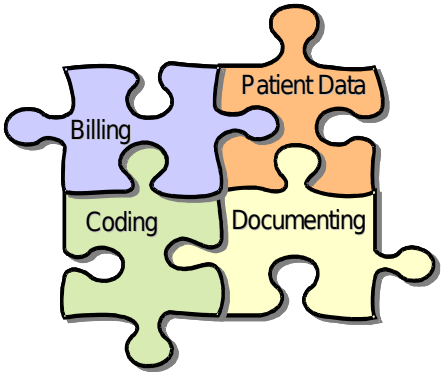


- OHI consists of **Policy** and **Coverage**:
  - Policy:
    - Carrier Name
    - Policy ID
    - Effective Calendar Date
    - HIPAA Insurance Type Code

      AP = Auto Insurance Policy; **CI** = Commercial (default);
      CP = Medicare Conditionally Primary; **HM** = HMO;
      GP = Group Policy; **IP** = Individual Policy;
      LD = Long Term Policy; **LT** = Litigation; **MB** = Medicare Part B;
      MC = Medicaid; **MI** = Medigap Part B; **MP** = Medicare Primary;
      PP = Personal Payment; **OT** = Other; **SN** = Supplemental Policy;

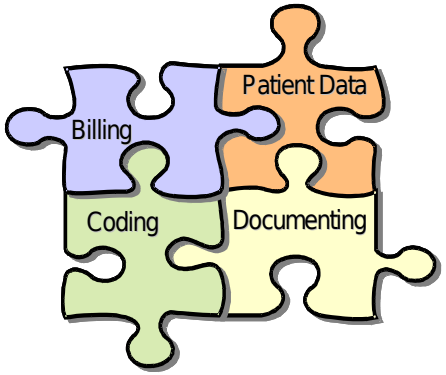
CORE COMPETENCIES

OHI
The Rest of the Story



- Coverage:
  - Coverage Type Code
    - Comprehensive Medical (default) (**XM**); Dental (**DN**); Inpatient (**IP**); Long Term Care (**LT**); Medical (**MD**); Mental Health (**MH**); Outpatient (**OP**); Partial Hospitalization (**PH**); Pharmacy (**RX**); Skilled Nursing (**SN**); Vision (**VI**);
  - Coverage Payer Type Code
    - **B** = both Institutional and Professional (default);
    - **I** = Institutional Only; **P** = Professional Only;
    - **N** = Nonbillable
  - Coverage Precedence Code
    - **1**= Primary (default); **2** = Secondary; **3** = Tertiary
  - Coverage Effective Date

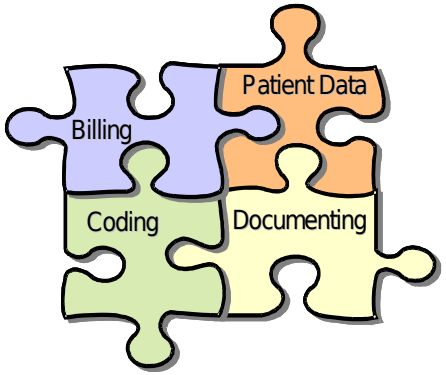
OHI Actions



- Add
- Update
- Cancel
- Automatic Termination

CORE COMPETENCIES

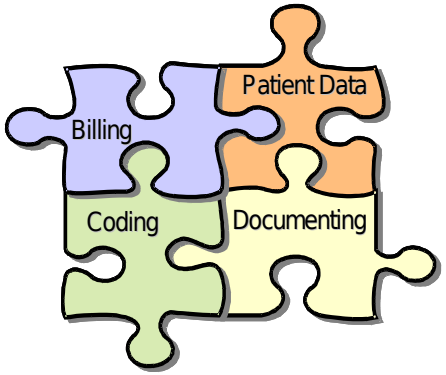
OHI Add



- Add Policy and Coverage
- Add Coverage to an Existing Policy
- Add Placeholder OHI Policies

CORE COMPETENCIES

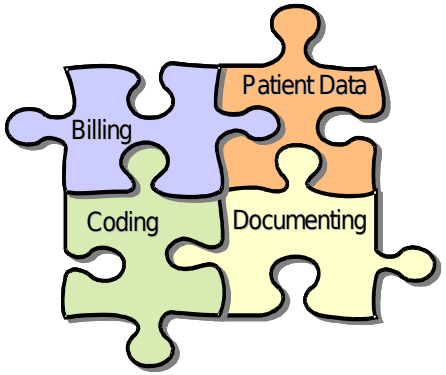
OHI Placeholder Policies

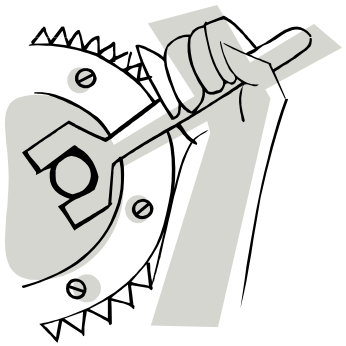


- **Carrier Name – Unknown**
- **Mailing Address – will pre-fill from SIT**
- **City and State – Falls Church, VA**
- **Carrier Telephone Number – will pre-fill from SIT**
- **Coverage Type Code – Comprehensive Medical (default)**
- **Payer Type Code – Both (default)**

CORE COMPETENCIES

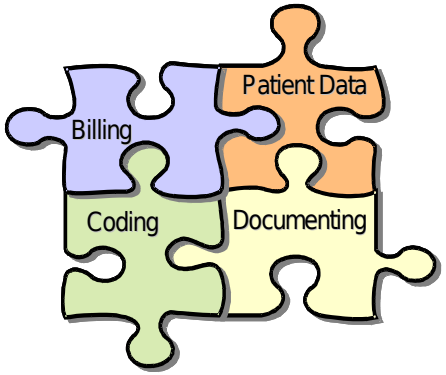
OHI Updates





- Update Policy and Coverage
- Update Policy Only
- Update Coverage Only

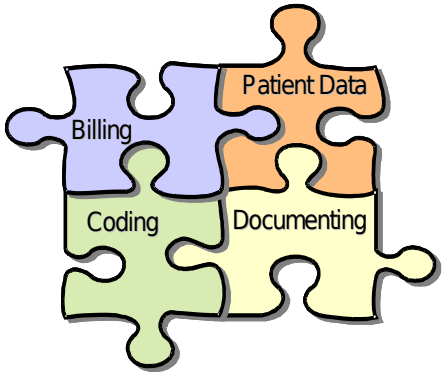
CORE COMPETENCIES



OHI Cancels

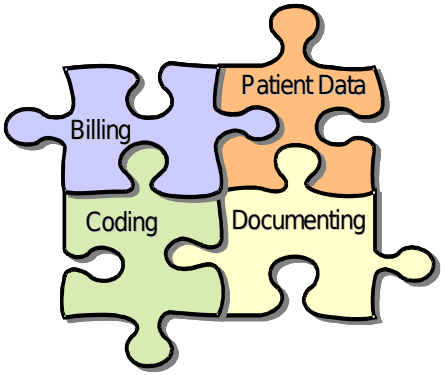
- Cancel Policy and/or Coverage Add
- Cancel Policy and/or Coverage Update

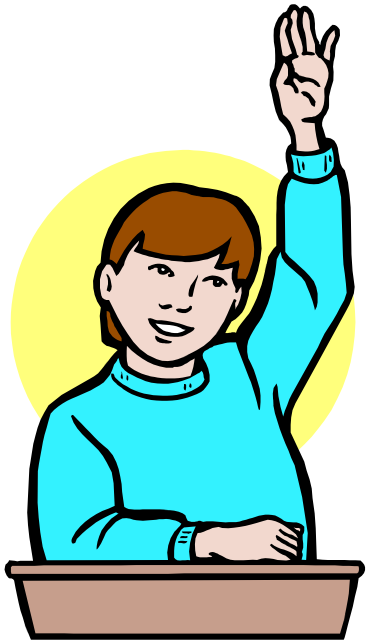
OHI Terminations



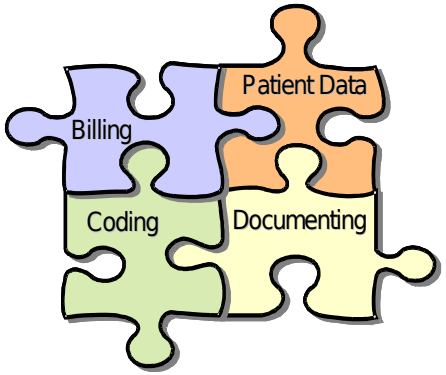
- Automatic Termination
  - Carrier Rejection
  - Carrier Deactivation
  - Carrier Cancellation

Questions?





CORE COMPETENCIES



Understanding the UB-92 Data Elements for Clean Claims

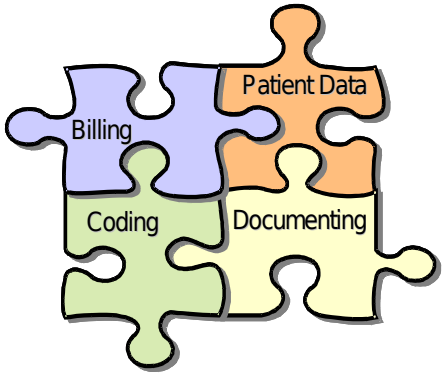
Lorrie Borchert, MA, CPC

May 19, 2005

Track 3 – UBO Basic

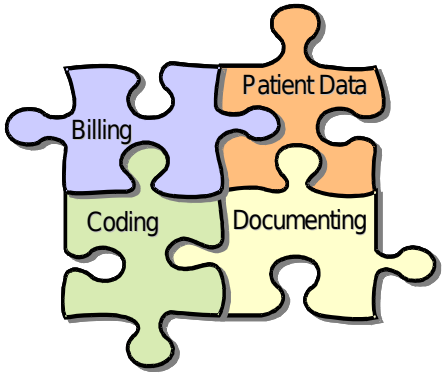
CORE COMPETENCIES

Objective



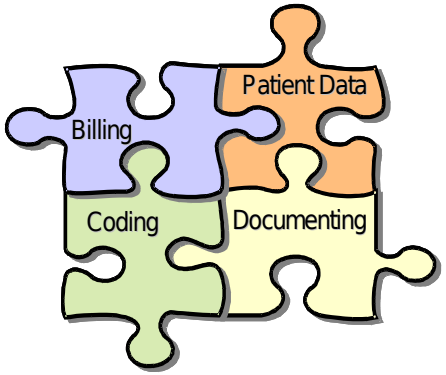
- Understand the UB-92 format
- Understand the 86 field locators
- Which ones do payers require?
- How clean claims impact cash flow
- E-billing and required data elements
- What's on the Horizon? UB-04!!

UB-92 Background



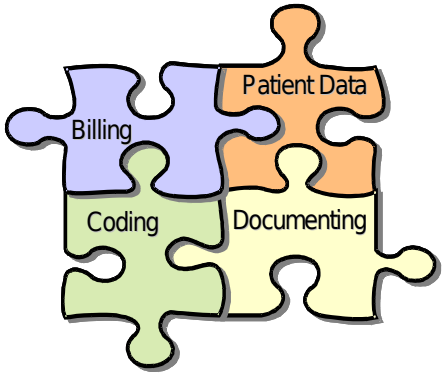
- Prior to 1980
- NUBC (National Uniform Billing Committee) met with insurance companies, patient account managers, government officials and coders
- To draft the UB-82 – it was approved and released in 1984
- Updates came in 1992 – called the UB-92

UB-04 On the Horizon



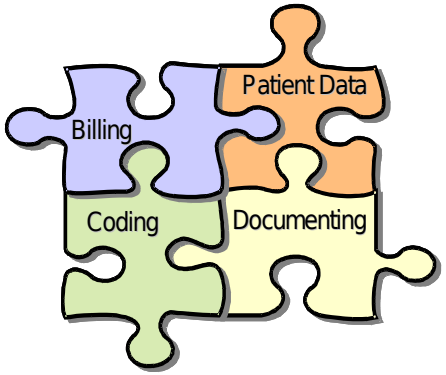
- NUBC has been meeting for the past several years to evolve the next updates on the UB-92
- The draft has been published and has been open to comments
- More on this topic later in this presentation

CORE COMPETENCIES



UB-92 Format in Detail

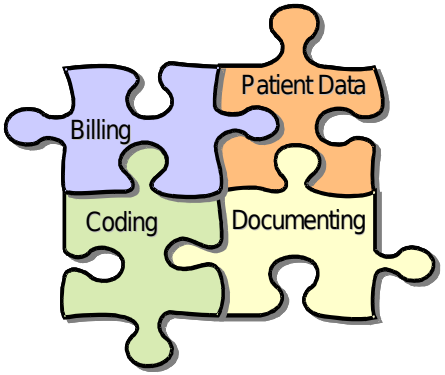
UB-92 Format



- The format breaks down into 5 sections:
  1. Demographic
  2. Services provided
  3. Subscriber information on payer
  4. Diagnostic
  5. Provider information

CORE COMPETENCIES

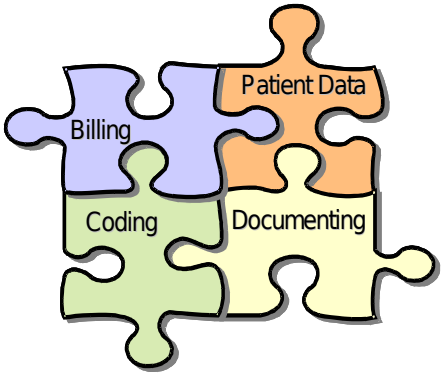
UB-92 – Section 1 Field Locators 1-23 Demographics



- Provider Information
- Patient Demographics (admission source)
- Type of Claim (type of bill)
- Patient Status Codes

CORE COMPETENCIES

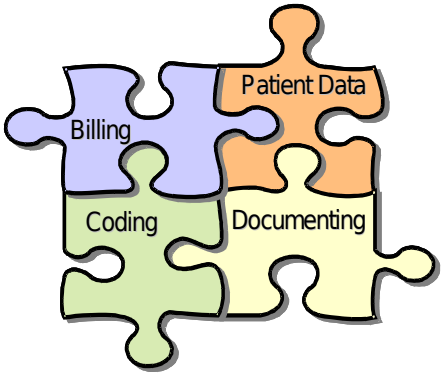
UB-92 – Section 2
Field Locators 24-41
Services Provided



- Are used by the payer to understand the need for medical services (for both inpatient and outpatient services) – are also used to define significant events.
- Condition Codes.
- Occurrence Codes.
- Value Codes.
- Insurance Coverage Conditions and monetary or clinical data that may affect payer processing and payment of claim.

CORE COMPETENCIES

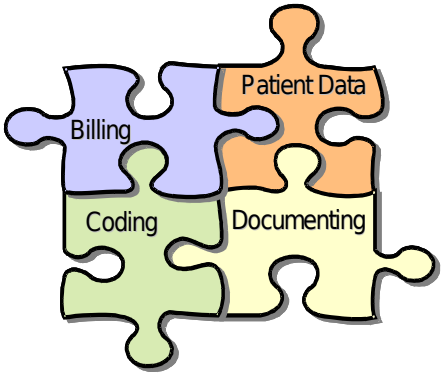
UB-92 Section 3
FL 42-49
Revenue Description Codes & Charges



- There are 23 lines available on the UB-92 claim form to list revenue codes & charges.
- FL 42 allows for a 4-digit revenue code that represents a specific accommodation, ancillary service or billing calculation.
- Revenue codes affect reimbursement for outpatient codes.

CORE COMPETENCIES

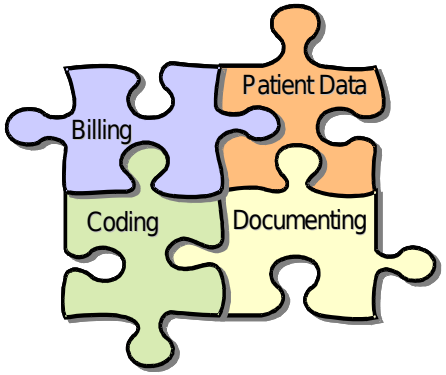
Revenue Codes Continued…



- *Directions in the UB-92 editor advise:* "to list revenue codes in revenue code order: ascending numeric sequence) by date of service (if applicable)."
- The revenue codes must be valid for the type of claim being billed: example: accommodation revenue codes (010x-021x) are not valid for outpatient claims.

CORE COMPETENCIES

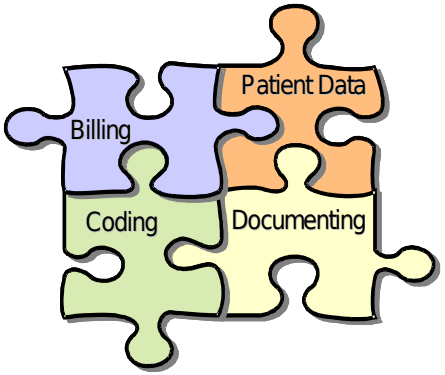
Revenue Codes Continued…



- Note: the total number of accommodation days in the units field (FL 46) must equal the covered days from admission through the discharge period shown by the “from” and “through” dates in the statement covered period (FL6).

CORE COMPETENCIES

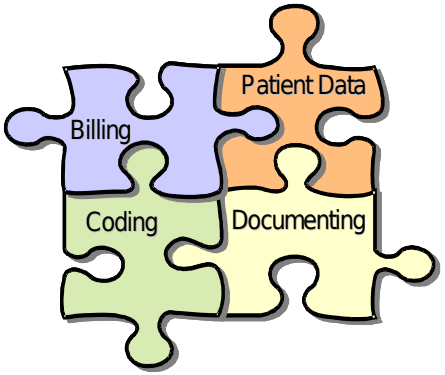
UB-92 Section 4 FL 50-56 Payer, Insured & Employer Information



- This section of the UB-92 correctly identifies the primary payer and any secondary payers.
- Commercial payers require the payer name and if available, the NAIC number and sub-code.
- Blue Cross for example, also requires a plan code (if it is indicated on the subscribers' ID card).

CORE COMPETENCIES

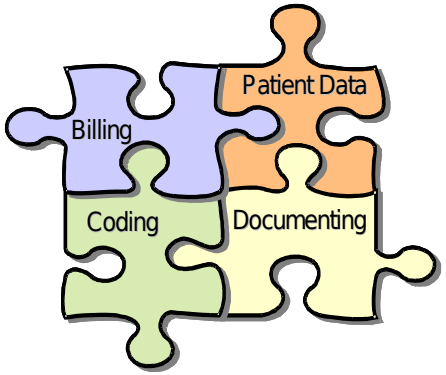
UB-92 Section 4 FL 50-56 Payer, Insured & Employer Information



- Provider number (FL 51)
  - CMS is in the process of issuing a national provider ID (NPI) to each provider to replace the current numbering system.
- FL 53 – Assignment of Benefit Certificate Indicator - this field shows whether the provider has a signed form authorizing the third-party insurer to pay the provider directly.
  - This is required for commercial insurance.

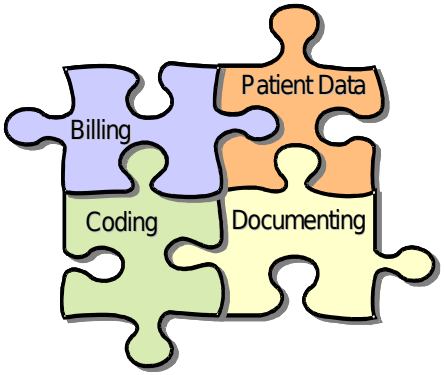
CORE COMPETENCIES

Section 4 continued…



- FL 55 – Estimated amount due – represents an estimate by the facility of the amount due.
  - Is required by commercial insurance.
- FL 58 – the name of the patient or insured individual in whose name the insurance is issued.
  - Is required for commercial and Blue Cross – need to enter the name as recorded on the ID card.

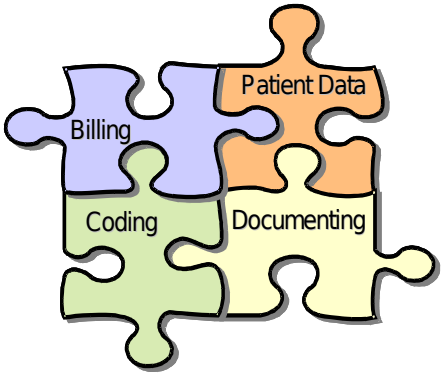
Section 4 continued…



- FL 59 – Patient's Relationship to the Insured
  - This field contains the code that indicates the relationship of the patient to the insured individual listed in FL 58.
- FL 60 – required for Commercial & BC
  - Enter the unique ID# on the ID card (including any alpha characters that precede or follow the contract/ID#).

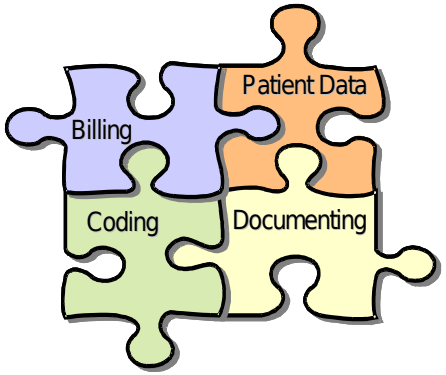
CORE COMPETENCIES

Section 4 continued…



- FL 61 – Insured Group Insurance – is used only when the plan needs or contract states it for group coverage.
  - It is not used for individual plans or coverage.
- FL 63 – Treatment Authorization Codes.
  - Designates that the treatment has been authorized by the payer indicated in FL 50.
- For BC – a notification number is required; for other commercial insurers – only if required.

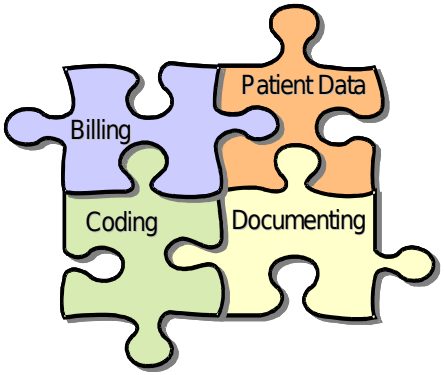
Section 4 continued…



- FL 65 – Employer name of insured
  - Contains the name of the employer that provides health care coverage for the insured identified in FL 58.
- FL 66 – Employer location
  - Is optional for BC and is required for Commercial insurers.

CORE COMPETENCIES

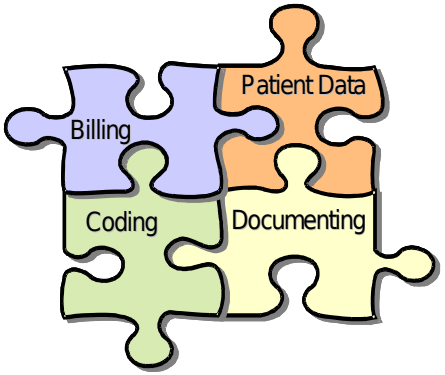
UB-92 Section 5
FL 67
Diagnostic and Procedure Coding



- These fields are used to report clinical information.
- FL 67 – contains the full ICD-9-CM diagnostic code (including 4th and 5th digit if applicable).
- This diagnosis code describes the principal diagnosis.

CORE COMPETENCIES

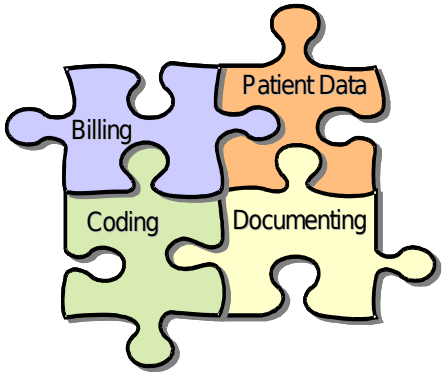
UB-92 Section 5
FL 67 - 75
Diagnostic and Procedure Coding



- FL 68-75 – Other Diagnosis Codes.
- These fields contain the full ICD-9-CM Diagnosis codes corresponding to all conditions that co-exist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay.

CORE COMPETENCIES

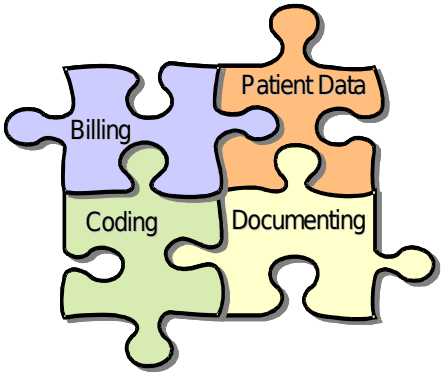
UB-92 Section 5
FL 67 - 75
Diagnostic and Procedure Coding



- UB-92 editor advises for inpatient: “code the condition established after study to be chiefly responsible for causing the hospital or use of other hospital services.”
- Guidance also states: “assign the most precise ICD-9-CM code that most fully explains the narrative description in the chart of the symptom or diagnosis.”

CORE COMPETENCIES

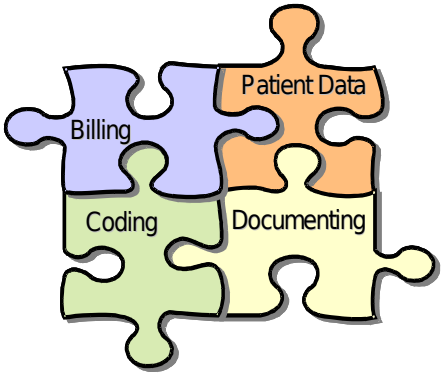
UB-92 Section 5
FL 67 - 75
Diagnostic and Procedure Coding



- The UB-92 editor reminds us that for outpatient claims – the ICD-9-CM coding guidelines instruct the provider to report the diagnosis based on test results.
- Also the guidelines state “to code the diagnosis to the highest degree of certainty.”

CORE COMPETENCIES

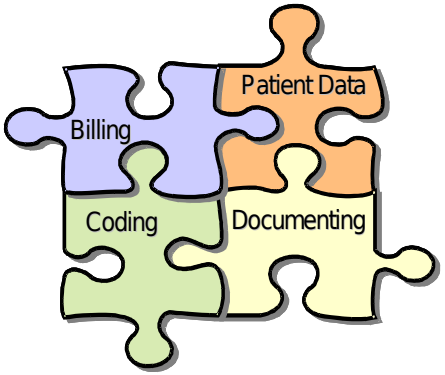
UB-92 Section 5
FL 68 - 75
Diagnostic and Procedure Coding



- "If the physician has confirmed a diagnosis based on the results of a diagnostic test, the physician interpreting the test should code that diagnosis.
- If the diagnostic test does not provide a diagnosis or was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study."
- Required for BC & Commercial Payers.

CORE COMPETENCIES

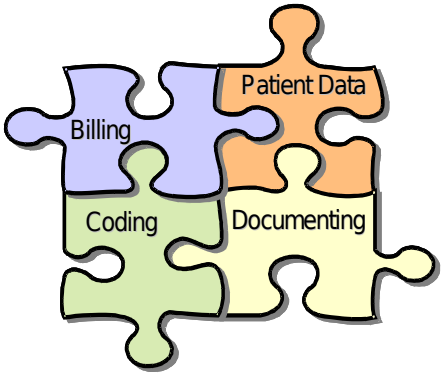
UB-92 Section 5
FL 67 - 75
Diagnostic and Procedure Coding



- FL 76 – Admitting Diagnosis/Patient's Reason for Visit – "report the complete ICD-9-CM code describing the patient's diagnosis or reason for visit at the time of admission or outpatient registration, including fourth and fifth digits when appropriate."

CORE COMPETENCIES

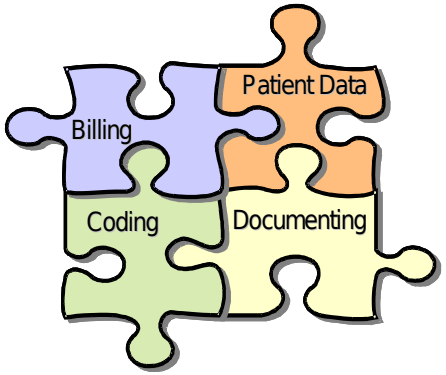
UB-92 Section 5
FL 67 - 75
Diagnostic and Procedure Coding



- For outpatient claims – “the ICD-9-CM code describing the patient’s stated reason for seeking care should be reported.
- When there is an unscheduled outpatient visit to the facility’s emergency room, the diagnosis code describing the patient’s reason for the visit should be reported in this field.
- This field is required when billing commercial insurance and may be required for BC claims depending on state needs/specific plan/contract.”

CORE COMPETENCIES

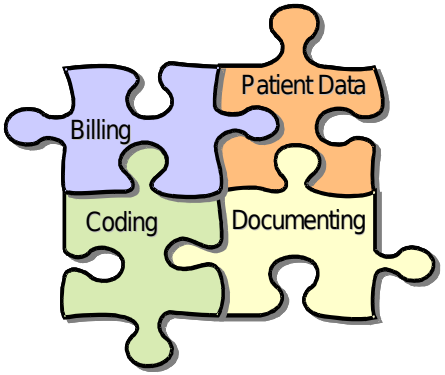
UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- FL 77 – External Cause of Injury (E Code) – per UB-92 editor guidance: “the full ICD-9-CM code, including the 4th and 5th digits (if applicable), for the external cause of injury:
  - Poisoning,
  - Injury,
  - Or adverse effect.”

CORE COMPETENCIES

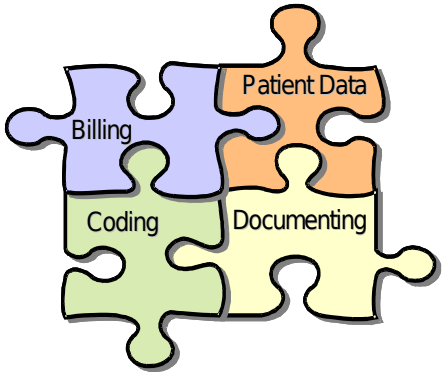
UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- FL 80 – Principal Procedure Code and Date – per the UB-92 editor: “this field contains the ICD-9-CM code for the principal procedure performed during the period covered by the bill and the date on which the principal procedure described on the bill was performed.”
- Note – HIPAA code set requirements do not allow the use of ICD-9-CM procedure codes on outpatient claims. Note – 1/05 CMS started rejecting any outpatient claim with ICD-9-CM – Volume 3 procedure codes on the claim.

CORE COMPETENCIES

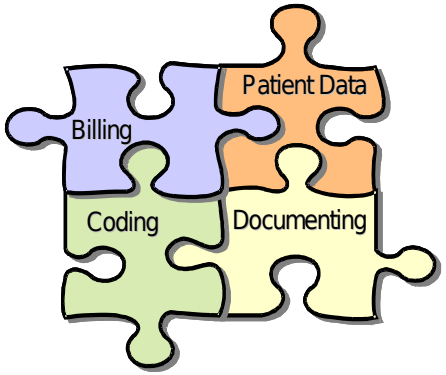
UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- Note – completion of this field (FL 80) is required for BC and Commercial third party payers.
- Inpatient claims require reporting the principal procedure if a significant procedure occurred during the hospitalization.
- It is also the procedure most closely related to the principal diagnosis.

CORE COMPETENCIES

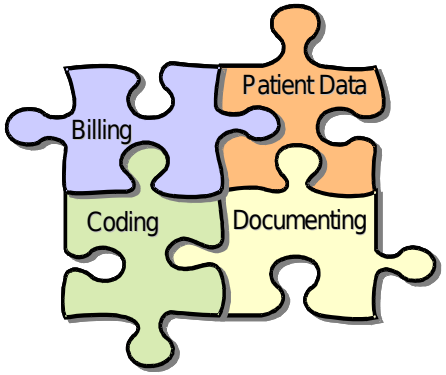
UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- FL 81 – Other Procedure Codes and Dates – For BC and commercial insurance inpatient claims, the ICD-9-CM procedure code and the date is required.
- For BC and commercial insurers outpatient claims, report the ICD-9-CM procedure code and the date or the CPT code.
- For electronic HIPAA-compliant claims, only CPT codes are allowed.

CORE COMPETENCIES

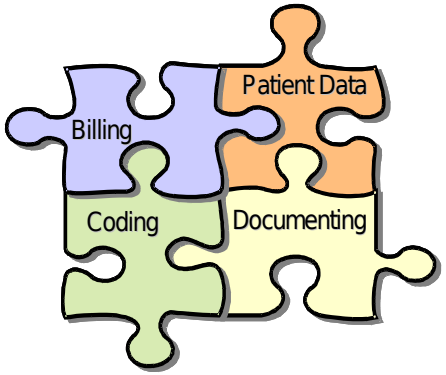
UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- FL 82 – Attending Physician ID – “this field identifies the name and/or number of the licensed physician who normally would be expected to certify and re-certify the medical necessity of the services rendered and/or who has primary responsibility for the patient’s medical care and treatment.”

CORE COMPETENCIES

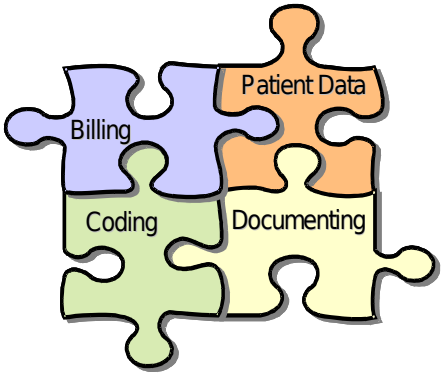
UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- For third-party payers, the following requirements apply:
  - BC requires UPINs on inpatient and outpatient claims based on plan's needs and specific contract requirements.
  - Commercial insurers require the physician's last name, first name and middle initial as the identification.

CORE COMPETENCIES

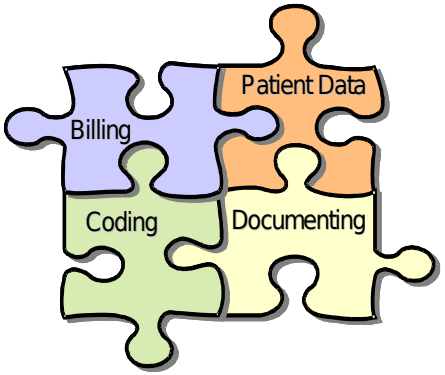
Section VI – FL's 84-86 Remarks, Provider Signature and Date



- FL 84 – Remarks – "this field is used to make notations relating to specific third-party payer needs.
  - Provide any additional information that is necessary to adjudicate the claim or otherwise fulfill the payer's reporting requirements."

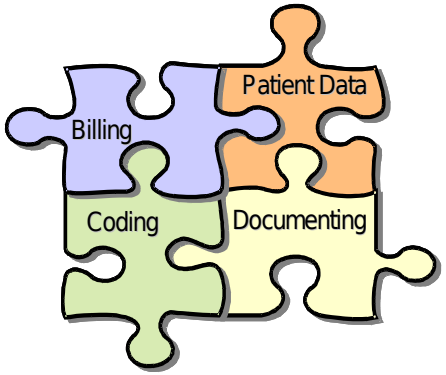
CORE COMPETENCIES

UB-92 Section 5
FL 67 - 83
Diagnostic and Procedure Coding



- FL 86 – Date Bill Submitted “this field is used to record the date the bill is submitted to the payer organization.”
  - This field is required for commercial insurers and for BC enter this information as required by plan needs or specific contract requirements.

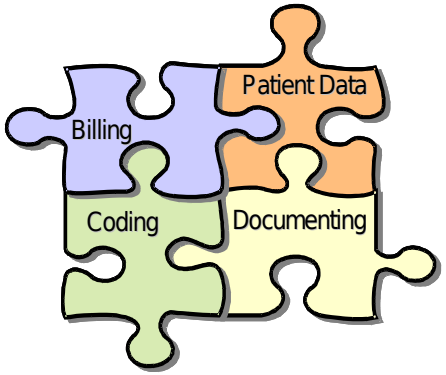
UB-92 Payor Rules



- Different payors have different rules when it comes to filling in the UB-92.
- How do you find these rules?
- In the private sector, the contract will often spell out which revenue codes are used for certain services and will list how the claim will be paid (case rate, per diem).

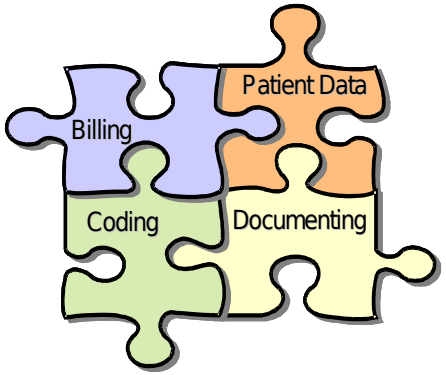
CORE COMPETENCIES

UB-92 Billing/Coding Edits



- Every insurance payer has edits built into their system.
- Some refer to these as the “black box” which means no one from the outside knows exactly what the edits are.

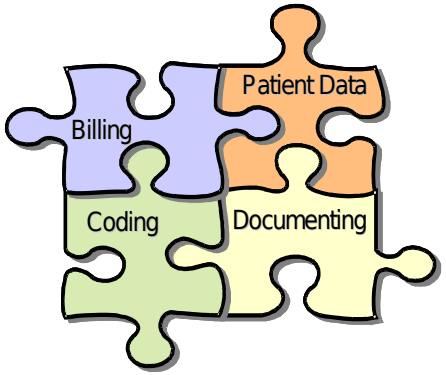
UB-92 – e-billing



- The transactions and code sets rule is an attempt to reduce the inefficiency created by the tremendous variety of formats -- paper as well as electronic -- now used by the health care industry in day-to-day business processes, such as enrollment of members and claims submission. For example, there are approximately 400 different formats for health care claims currently in use.

CORE COMPETENCIES

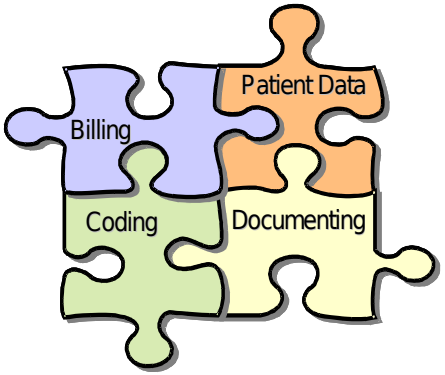
UB-92 – e-billing



- The new standards specify:
  - Claim submission - When a medical care provider (e.g., physician, dentist, hospital) files an electronic claim for payment for health care that has been delivered, the claim must be in the electronic data interchange HIPAA format known as X12-837, similar in many respects to the UB-92 and the HCFA 1500 formats with which you may be familiar. Under HIPAA law, health plans (also payers or insurers) must accept and process without delay the standard HIPAA claim submitted by a provider electronically.

CORE COMPETENCIES

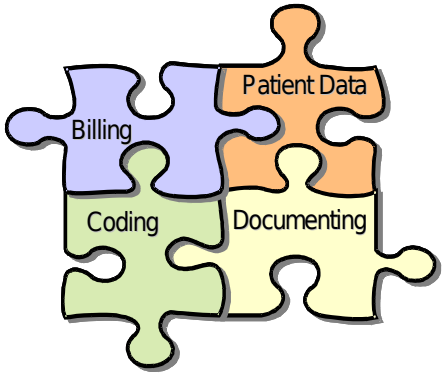
e-billing - 834



- Enrollment & dis-enrollment in a health plan - The X12-834 HIPAA transaction will be used to establish communication between the sponsor of a health benefit and the health plan.
- The sponsor is the ultimate payer of the coverage, benefit or product, and can be an employer, union, government agency like Medicare or Medicaid, or an insurance company.
- The health plan refers to an entity that pays claims, administers the insurance product or benefit, or both.
- It provides enrollment data, such as subscriber and dependents, employer information, and health care provider information.

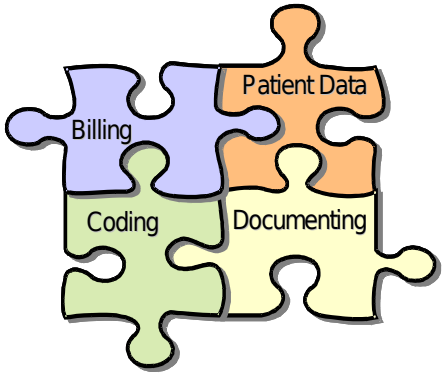
CORE COMPETENCIES

E-billing 270 and 271



1. Eligibility for a health plan (benefit eligibility inquiry & response):
   - The X12-270 (inquiry) & X12-271 (response) HIPAA transactions will be used to inquire about the eligibility, coverage, or benefits associated with a benefit plan, employer, plan sponsor, subscriber, or dependent under the subscriber's policy.
   - It also can be used to communicate information about or changes to eligibility, coverage, or benefits from information sources.

E-billing - 835

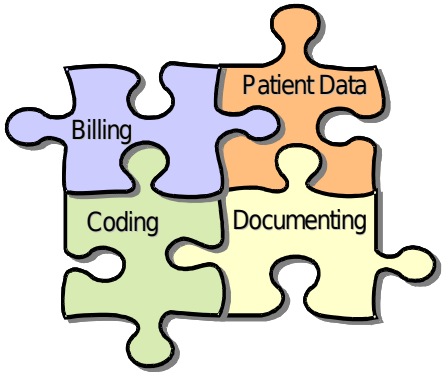


Health care payment to provider (with remittance advice):

- The X12-835 HIPAA transaction will be used by a health plan to make a payment to a financial institution for a health care provider (sending payment only).
- To send an explanation of benefits or a remittance advice directly to a health care provider (sending data only).
- Or to make payment and send an explanation of benefits remittance advice to a health care provider via a financial institution (sending both payment and data).

CORE COMPETENCIES

Claims Transition from Paper UB-92's to Electronic:

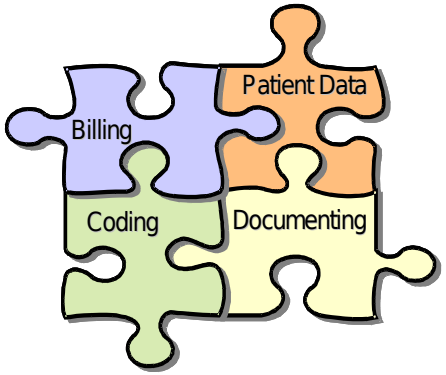


Why must we transition to a different electronic claims format?

HIPAA requires it. Providers submitting electronic claims must do so in a format that is either HIPAA-compliant or that can be translated into a HIPAA-compliant format. The current electronic formats (ECC, NSF and UB92 Flat File) do not have all of the data elements needed to translate it into a HIPAA-compliant format.

CORE COMPETENCIES

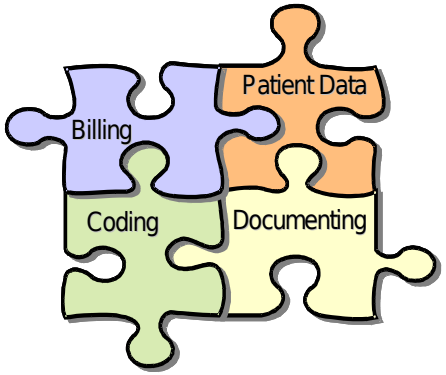
Claims Transition from Paper UB-92's to Electronic:



- In the future, only two formats will be accepted for electronic claims. Professional claim submitters can use either **NSF version T0301** or **ANSI 837**. Institutional claim submitters must use **ANSI 837**. ANSI is the standard HIPAA format and 837 is the health-care claim transaction set.

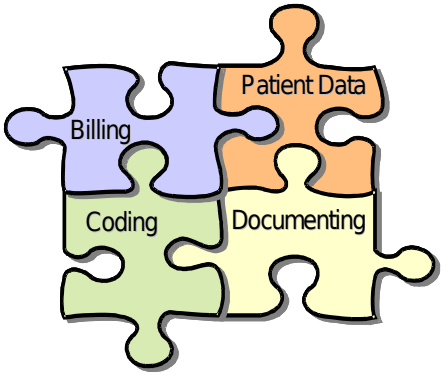
CORE COMPETENCIES

What Changes on the New Claim Form?



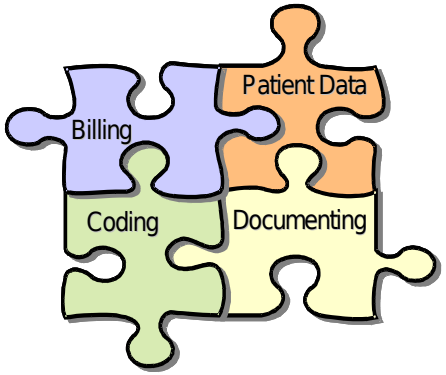
- There are 46 changes from the current UB-92 to the UB-04.
- As we get closer to implementation, training on the differences will need to take place so that cash flow is not impacted during the transition.

Summary



- It's important for us to understand the UB-92 format – to know which elements are required by which payers – and to understand just how important these elements are to improving our cash flow.
- E-billing and required data elements are on the horizon for MHS – it's important to understand the elements and the relationship between the facility and the payer.

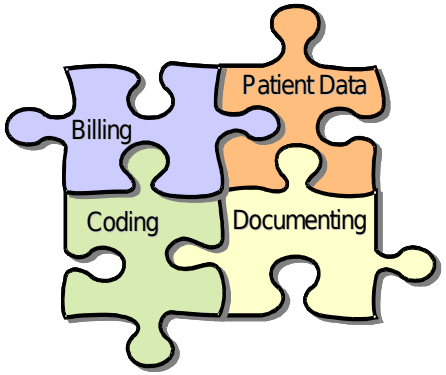
CORE COMPETENCIES



Thank you for your kind attention!!

Any Questions??

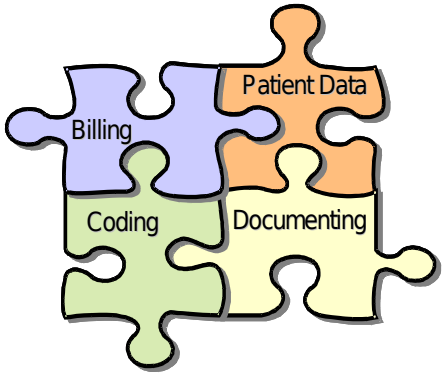
CORE COMPETENCIES



Wrap-Up, Tracks 1/2/3/4

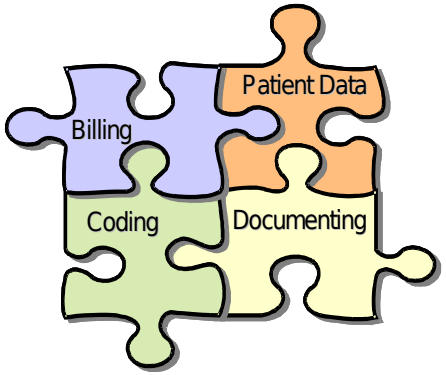
Lt Col Jeanne Yoder
UBO Program Manager
Thursday, 1300, 19 May 2005

Your Home Work



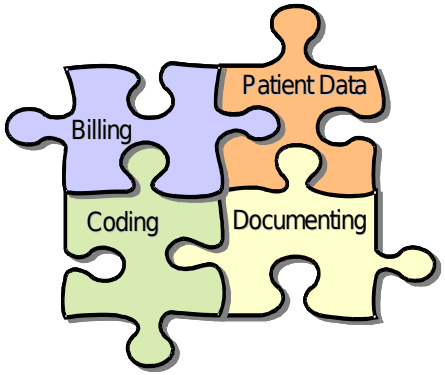
- Review/update your compliance plan
- Training
- Billers – set up meeting with your coders, understand why bills are denied for coding reasons
- Coders – go talk with billers, find out the coding problems, figure out solutions, implement; denied bills are errors you find without needing to audit

The Process – Provider New to Military Treatment Facility (MTF)



- Provider Specialty Code
- HIPAA Taxonomy
- Abbreviations
- Timeliness of completion of documentation/data entry in ambulatory data module (ADM)
- Institutional versus professional
- Introduce the provider to his coder

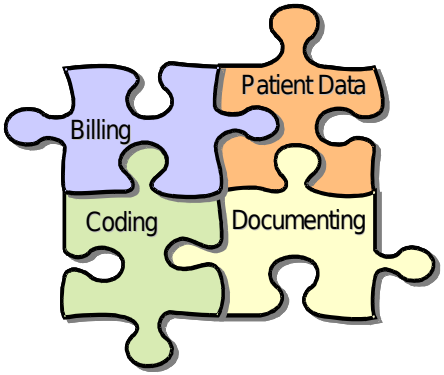
The Process – Sit Down One-On-One With Provider



- Document what you do, not just abnormals
- Document conditions/diseases that impact care
- ICD=diagnosis, medical necessity, reason for services
- CPT/HCPCS=what was done, supplies
  - Don’t get credit unless documented
  - Relative value units (RVUs)

CORE COMPETENCIES

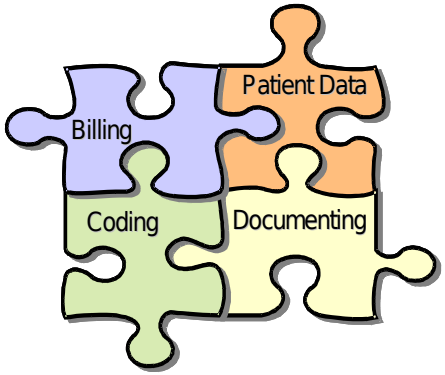
The Process – Sit Down One-On-One With Provider



- **Brief provider on how to document**
- Subjective Objective Assessment Plan
- S=HPI, ROS, P/F/S Hx
- O=Vital Signs, General, Body Systems
- A=What found
- P=What you did/and plan to do (e.g., TREAT FX)

- **Military unique issues**
- DoD Extender Codes
- Telephone Consults
- Services “downtown”
- Labs/Rads/EKGs/ vaccinations, in the clinic or not in the clinic

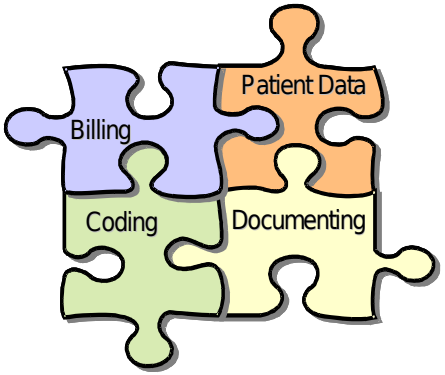
The Process – Sit Down One-On-One With Provider



- What they can dictate (e.g., H&P, operative reports, consults, D/C summary, MEBs)
- What must be in the operative report
- Reviewing and signing dictation, no “SBNR”
- Ours is a decentralized medical record, that the OB, Mental Health and Dental components are usually stored separately

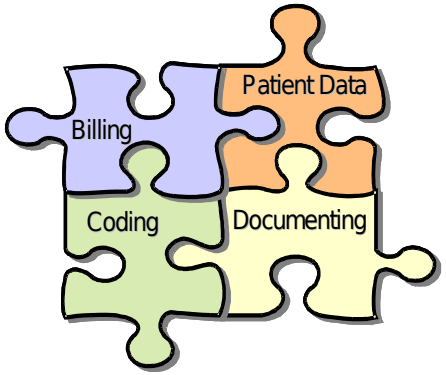
CORE COMPETENCIES

The Process – Sit Down One-On-One With Provider



- Layout of the 4 part medical record
- Documentation on the Summary Sheet counts if Summary Sheet current
- Auto fill function for diagnosis if used (usually only Mental Health and OB), must delete diagnoses not addressed/considered at that encounter
- Auto-negative function in CHCSII, must change if not addressed

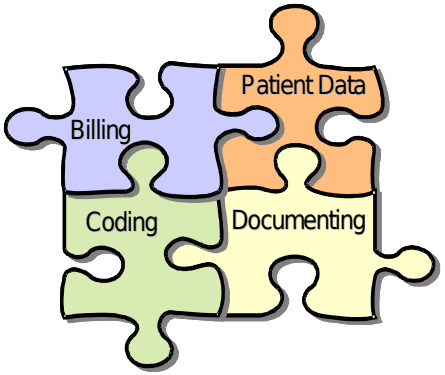
The Process – Sit Down One-On-One With Provider



- Difference between:
  - Consult and referral
  - Office visit and physical
  - New and established patient
  - Conscious sedation, monitored anesthesia care and anesthesia
  - Office visit and optometry/ophthalmology code
  - Telephone consult (workload does count) and telephone call (workload does not count)

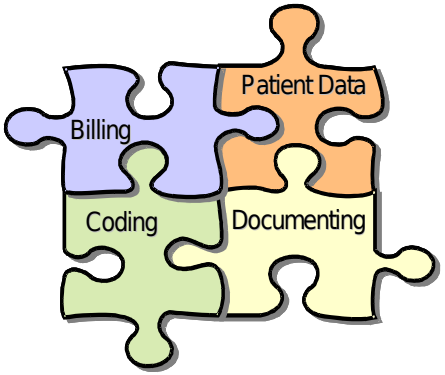
CORE COMPETENCIES

The Process – New Provider One Month Later



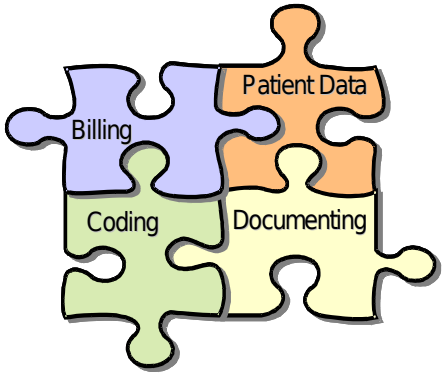
- Feedback and answer questions
  - Review audit findings one-on-one with the provider
  - "If you did this, you should have documented it, you would have had a 99213 instead of a 99212…"
  - Need to know right and left, which finger on which hand; need name of nurse helping with conscious sedation; did you replace the cast or not…

The Process – The Coding Audit



- Always provide individual feedback
  - If there were no findings, let him know, even if it is just a letter “Reviewed 10 of your encounters with no coding errors found.”
- If errors found that could be applicable to multiple specialties, brief at Professional Staff Meeting

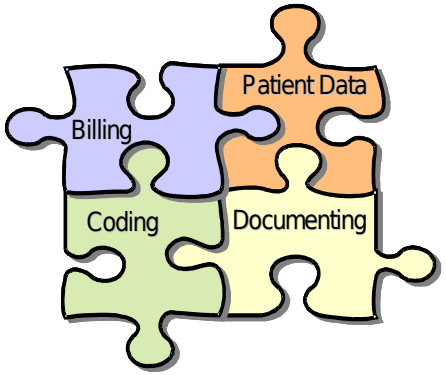
The Process – Brief at Professional Staff



- External Cause Of Injury Coding
- DoD Extenders to include Deployment Related
- Injury Logs, or at least the Injury/Accident flag
- Medical Affirmative Claims records must be back in file at end of duty day

CORE COMPETENCIES

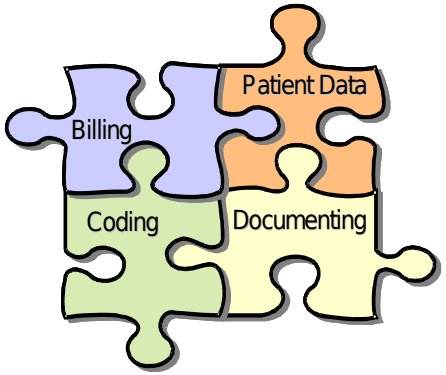
The Process – Patient is New To MTF



- Collect patient data to include DD Form 2569
  - Send form to UBO office for entry into CHCS
- Patient's address and telephone number (check and update every time the patient makes an appointment)
  - Update on DMDC web site

CORE COMPETENCIES

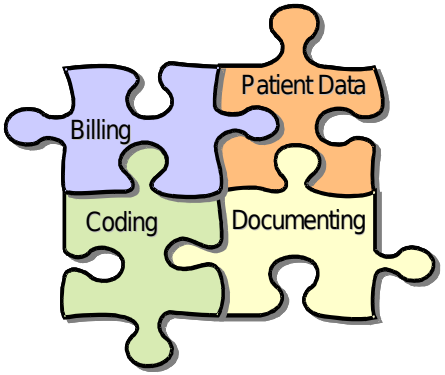
UBU Home Work



- Teach providers how to document
- Teach admission clerks and appointment clerks
  - PATCATs and how to change them for each encounter
  - Injury/Accident flag
- Audits – get the results of external audits from your Service POCs
- Audits – are not complete until there is provider feedback (both positive and how to improve)
- Get 5 minutes every month at Professional Staff for audit findings, new codes, documentation…
- Coding/documentation in-services

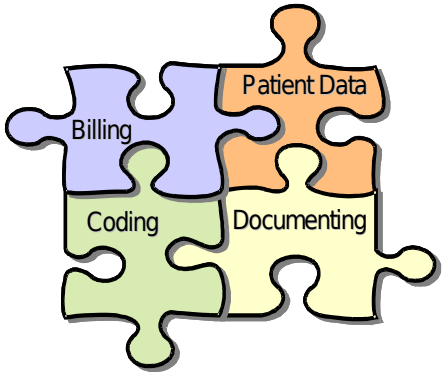
CORE COMPETENCIES

The Process – What Will Generate A Third Party Bill



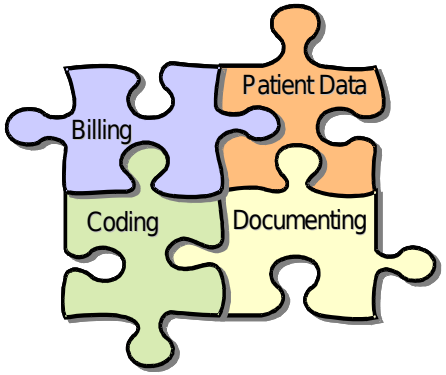
- NOTHING unless DD 2569 data is in CHCS
- Privileged provider visits, not technician visits
- CHCS Provider Specialty Code 000-901, except 900
- HIPAA taxonomy

The Process – What Will Generate A Medical Affirmative Claim (MAC)



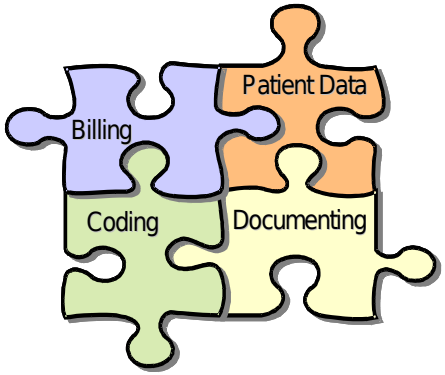
- Patient care due to injury caused by another party who has insurance, or by the patient who has insurance (e.g., single car accident)
- Injury Log
- Strong MAC program
- Claim data sent to Legal upon completion of care for that injury
- Understand use of ICD E-codes and follow-up codes

UBO Overview



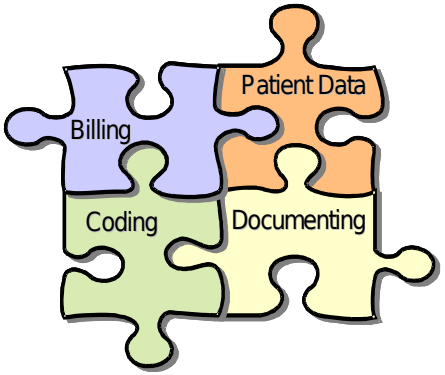
- 3 Major Cost Recovery Programs
  - Third Party Collection (TPC)
  - Medical Services Accounts (MSA)
  - Medical Affirmative Claims (MAC)
- Other Cost Recovery Program
  - Dept of Veterans Affairs Joint Venture

Electronic Billing



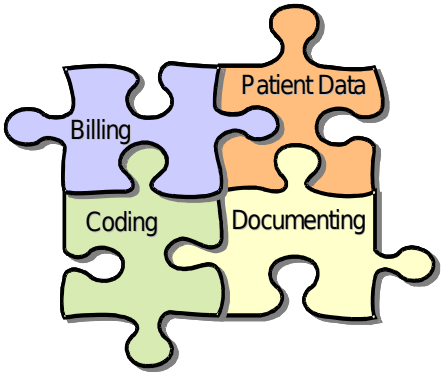
- Work with your credentials staff to ensure provider data are correct
- Costs less to process claim electronically
- Know that day if something is missing on the electronic claim
- Remittances faster
- No deductions because of using paper bills

Provider Specialty Code



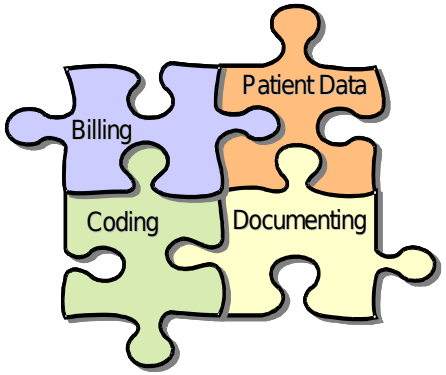
- Impacts TPC
  - Only generate bills for codes 000-901 (except 900)
  - If no provider specialty code (field left blank) – does not feed to Third Party Outpatient Collection System (TPOCS)
- Enter during provider inprocessing to the MTF and when status changes (e.g., resident to fully privileged provider)
- Work TPOCS edit list EVERY day

Correct PATCAT Classification



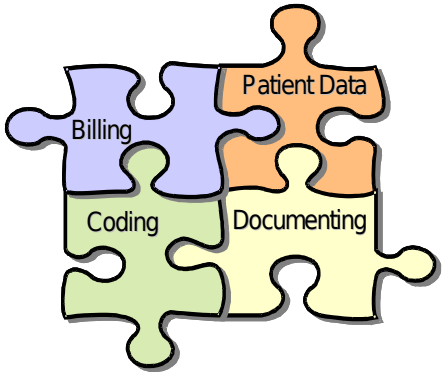
- Impacts Medical Services Accounts (MSA)
- Coast Guard = C, this care is billed back to the Coast Guard IF the PATCAT is correct
- Uniformed Services is more than the Army, Navy, Air Force and Marines
  - NOAA, PHS, Coast Guard
- Patients with multiple benefits
  - VA and DoD; Retired and Occupational Screening; Family Member and Reservist; DoD School and Retire/Family Member…

GAO Audit



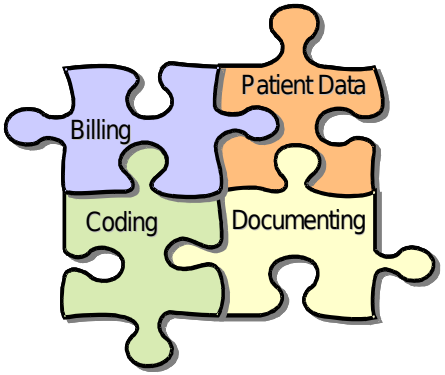
- 20 Feb 2004, MTF: Improvements Needed to Increase DoD Third-Party Collections, page 3, 1st and 2nd sentences
- "The single biggest obstacle to increasing collections, however, is inadequate identification of patients with third-party insurance. DoD does not have effective systems or processes for obtaining and updating insurance information for patients that have other health insurance coverage."

DD Form 2569



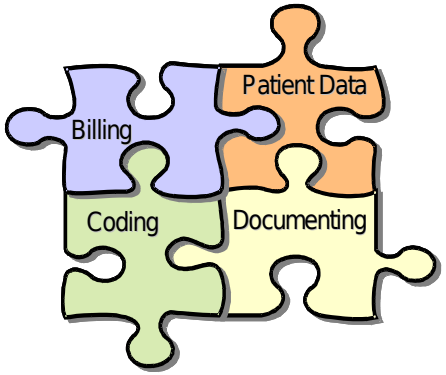
- DD Form 2569 - Third Party Collection Program – Record of Other Health Insurance
  - Also used for MSA
  - Current within past 12 months
  - The 2569 must be signed during each inpatient stay and APV visit
  - In outpatient medical record (which is why YOU need to start medical records at YOUR MTF for non-enrollees)
  - In CHCS (how system knows to feed data to TPOCS)

Injury Log



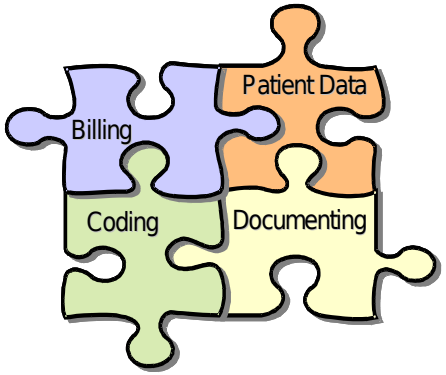
- Impacts Medical Affirmative Claims (MAC)
- Clinics (particularly Emergency Department and primary care clinics) need to identify patient's initial treatment for all injuries
- Clinic staff need to understand importance of using injury log
- Systems Change Request funded to have "Injury/Accident" prompt when making appointment and at patient check-in

Completed MAC



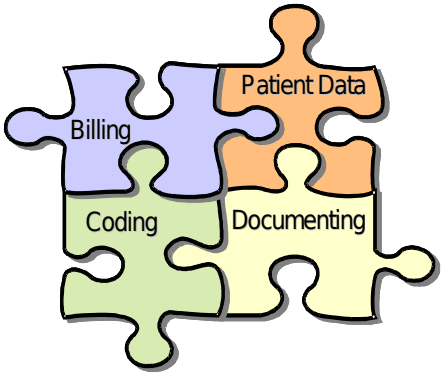
- If MAC patient is not seen for 30 days
  - Review CHCS for walk-in visits, t-cons, etc
  - Check last documented soaP (plan) for the injury
  - Ask provider if care is complete
- Generate bill and forward to legal

Cosmetic Surgery



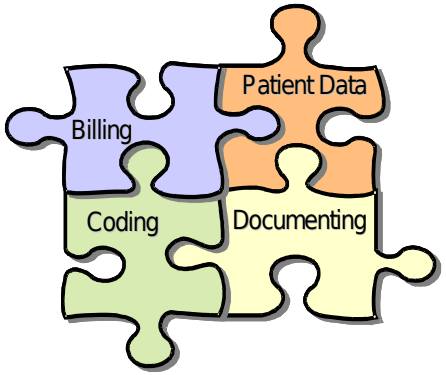
- NEW billing method with release of next rates package – contact your Service POC if you do cosmetic surgery billing and did not attend the class
- Impacts Medical Services Accounts (MSA)
- Be sure your clinicians know to send patients scheduled for cosmetic surgery to the MSA office
- Clinician determines if it is cosmetic surgery or reconstructive surgery

Accounts Receivable



- Impacts TPC, MSA
- Follow-up, follow-up, follow-up
- Congressional TPC Reporting
  - Inpatient: Claims/disposition, 10%
  - Inpatient: Collected to billed, 45%
  - Inpatient: Closed to billed, 60%
  - Outpatient: Collected to billed, 50%
  - Outpatient: Closed to billed, 45%

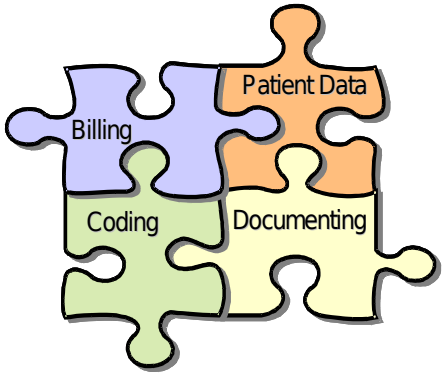
TPOCS Edit List



- Impacts outpatient TPC
- Work it every day
  - Once it is cleaned up, it is easy to keep it cleaned up

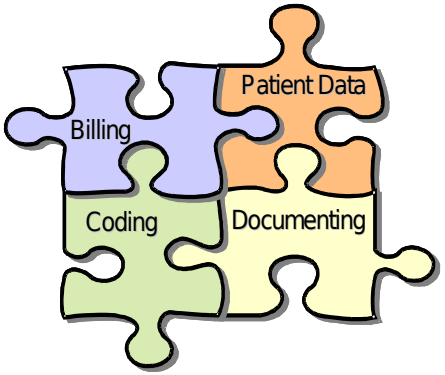
CORE COMPETENCIES

UBO Home Work



- UBO Priority List
- Electronic Billing
- Provider Specialty Code
- PATCAT
- DD Form 2569
- Injury Log
- Forward completed MAC packages to legal
- Accounts Receivable
- TPOCS edit list
- Cosmetic Surgery

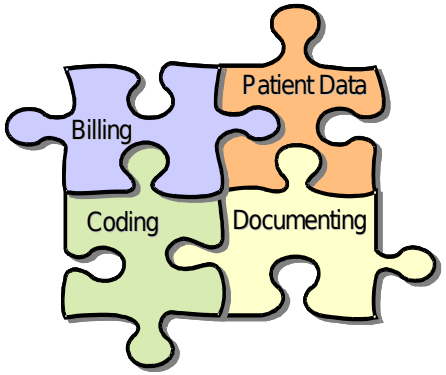
Coding



- Impacts TPC, MSA, MAC
- Review the new MHS Coding Guidance
- http://www.tricare.osd.mil/org/pae/ubu/default.htm
- Document what is done
- Code what is documented

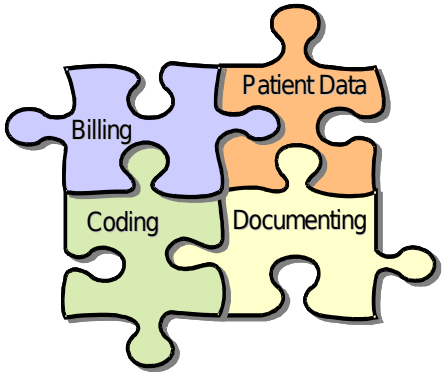
CORE COMPETENCIES

Objective



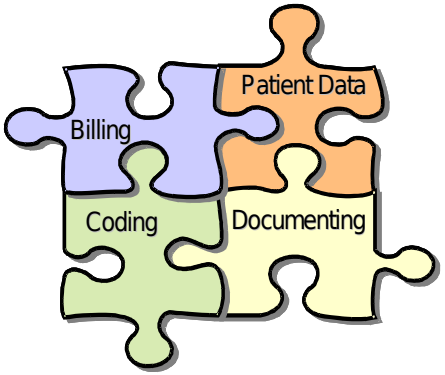
- Know how to increase MTF revenue
  - Provider Specialty codes in CHCS
  - Correct PATCAT codes
  - Cosmetic Surgery
  - DD Form 2569
  - Injury Log
  - Forward completed MAC packages to legal
  - Coding
  - TPOCS edit list
  - Accounts receivable management

Summary



- Review/update your compliance plan
- Training
- Billers – set up meeting with your coders, understand why bills are denied for coding reasons
- Coders – go talk with billers, find out the coding problems, figure out solutions, implement; denied bills are errors you find without needing to audit

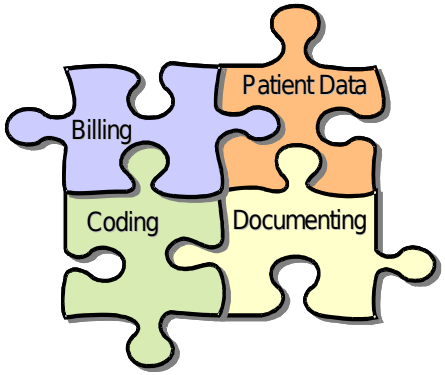
BOTTOM LINE:



- Have a safe trip home
- Share what you have learned

CORE COMPETENCIES

Questions



- Fill out your class comment forms
- Comments improve future classes
- Turn in comment form for a CD with all the class briefings – excellent to use as teaching component of your compliance plan
- At the same time, pick up your course participation form
- Keep your handouts with comments for Continuing Education documentation
- Next class: Service Breakouts